

**SAN FRANCISCO
HEALTH PLAN™**



Here for you

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Claims Operations Manual

For Providers

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Introduction

San Francisco Health Plan (SFHP) was established in 1994 by the San Francisco Board of Supervisors. SFHP is an award winning, managed health care health plan whose mission is to improve health outcomes of the diverse San Francisco communities through successful partnerships. SFHP is chosen by eight out of every ten San Francisco Medi-Cal managed care enrollees and our members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services through the Medi-Cal program. The objective of this Claims Operations Manual is to provide a summary of billing practices as a guide for our provider network.

Medi-Cal Billing

San Francisco Health Plan (SFHP) generally follows policies and procedures of the Medi-Cal program. Unless otherwise noted, SFHP's non-Medi-Cal lines of business and Healthy Workers HMO also follows Medi-Cal policies and programs guidelines for claim adjudication. Providers have access to SFHP policies and procedures in this manual. The Medi-Cal program manual may be found at the following website: medi-cal.ca.gov.

Conduent State Healthcare, LLC is contracted by the State as the Medi-Cal fiscal Intermediary for the State Medi-Cal program. Conduent State Healthcare, LLC processes and pays claims for Medi-Cal beneficiaries in Medi-Cal Fee-for-Service. SFHP is responsible to process and pay claims for its members only. If you treat a member who is not a SFHP member, you must

bill Conduent State Healthcare, LLC or the member's Medi-Cal managed care plan for those services. This rule applies to members whose eligibility is through another county or who have an aid code not covered by San Francisco Health Plan.

Authorization Requirements

Any of the services or benefits outlined below are subject to prior authorization requirements. SFHP follows Medi-Cal benefit guidelines; however, the prior authorization requirements may not match the treatment authorization request (TAR) requirements listed on the state Medi-Cal website. For the most up-to-date list of prior authorization requirements, please visit our website at sfhp.org, contact us at **1(415) 547-7818 ext. 7080**, or contact the



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UM department for the member's delegated medical group (please See **Appendix A** for contact information).

shall be governed by your practice or medical group's contract with SFHP. For any questions or clarity about your contract, you can contact our Provider Relations department at **1(415) 547-7818 ext. 7084**.

Contracts

Any service or benefit described in this manual is considered the general rule. The terms and conditions of your practice or medical group's responsibilities for claims, to the extent they conflict with this manual,



Claims Submission and Processing

This section explains claims submission requirements and general claims processing information.

Claims Contact Information

San Francisco Health Plan (SFHP) delegates authorization and claim processing to some of its medical groups. SFHP processes claims, in general, for the following medical groups: San Francisco Community Clinic Consortium, San Francisco Health Network (SFN), Community Clinic Network (CLN), and UCSF Medical Group. See **Appendix A** for more specific information. Any delegated medical group must submit encounter data to San Francisco Health Plan in lieu of claims. For more information on delegated responsibilities or encounter data please see the Network Operations Manual posted on our website at sfhp.org.

See Appendix A for contact information for other than SFHP.

Claim Submissions

Electronic Claims

SFHP prefers that claims be submitted electronically in a HIPAA 5010 837-compliant format. For information on file layouts, assistance on submitting electronic claims, or to obtain a copy of the **SFHP 837 Companion guide**, please contact the SFHP

Information Technology Services Department at **1(415) 615-4411** or email at **production_services@sfhp.org**.

EDI information and documentation can be found here: **sfhp.org/providers/our-network/edi/**

Provider Portal Claims Submission



Providers may submit Professional (CMS 1500) claims electronically using the **SFHP Provider Portal**. This can be accessed on our website at **sfhp.org**. Once registered and logged on, navigate to Patient Management > Claims or Office Management > Claims from the Portal home screen. For further information on claims submission using our **SFHP Provider Portal**, please contact Provider Relations at **1(415) 547 7818 ext. 7084**.



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Checking Claim Status

Providers may check claim status as well as eligibility and authorization status through the **Provider Portal**. Providers may also call SFHP's claim line at **1(415) 547-7818 ext. 7115**.

Claim Timelines

SFHP complies with AB1455 timeline guidelines. SFHP adjudicates each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but not later than 45 working days after the date of receipt of the complete claim. For more information of the requirements for a complete claim, please refer to the **Clean Claims** section. The receipt date used for claims processing on claims submitted through the mail is the actual date the claim was received at SFHP. Electronic claims submitted after 5:00pm are assigned to the following business day's receipt date.

Interest and Penalties

Interest rates and penalties are paid as applicable:

- If SFHP has received all of the information necessary to determine SFHP liability for a contested claim, and has not reimbursed a claim that has been determined to be payable within 45 working days of receipt of that information, interest accrues and is payable at a rate of 15 percent per annum beginning with the first calendar day after the 45-working-day period.
- Interest payments for emergency room and emergency transportation claims are calculated at 15 percent or \$15.00, whichever is higher.
- If the interest payment is not included with the claim payment when required, a \$10.00 late claim fee are to be included in addition to any amounts due.

Billing Limits

San Francisco Health Plan has billing limits based on Medi-Cal guidelines, as outlined below:

Reimbursement Percentage	
Claims Received Between:	Pay at:
7 th –9 th Month	75% of Payable Amount
10 th –12 th Month	50% of Payable Amount
After the 12 th Month	Zero Payment

The original claim should be billed to SFHP as soon as possible from the date of service. However, the original clean claim must be received at SFHP within 6 months of the date services were rendered to avoid a reduction in payment. After six months from the service date, there is a payment reduction as defined by Medi-Cal regulations as shown in the diagram above. Claims received after 365 days from the Date of Service or the primary payer paid date will be denied for untimely filing. This requirement is referred to as the **One-Year Billing Limit**. Again, a corrected claim will be handled the same as an original claim and will be subject to the same timelines as noted in the diagram above.

Clean Claims

SFHP will process a clean and complete claim that is submitted in a timely manner for medically necessary and covered services by a participating provider group in accordance with the agreement between SFHP and the provider group for the applicable benefit program.

A clean claim is defined as a fully completed claim that contains all the required data necessary (including any essential documentation) for accurate adjudication.



For a list of the required fields by form see **Appendix B** or the link below.

For EDI information:

sfhp.org/providers/our-network/edi/

Other Claim Requirements

- **Multiple page paper claims:** In order for SFHP to convert these claims successfully into a useable electronic format, we ask that our Providers do not place a TOTAL CHARGES amount on the claims pages until the last page of the claim. The last page should be the total charges for all pages
- **National Drug Code (NDC)/Unique Product Number (UPN):** Include whenever applicable. NDC codes are required per Medi-Cal guidelines
- **Quantities:** A quantity for each service rendered is required. Please enter quantities as a single digit (e.g., “1” not “01,” “001” or “010”). Please do not use decimals or partial units, like “4”
- **Attachments:** Individual claim forms are separated. Each claim is processed separately. Do not staple original claims together. Stapling original claims together indicates the second claim is an “attachment,” not an original claim to be processed separately
- **Professional/Facility Services:** Do not bill both hospital professional and facility services on the same form.
- **NOTE:** If this procedure is not followed, services billed incorrectly will be denied.
- **Authorizations:** Prior authorization of services is required for some services and procedures; see sfhp.org/files/providers/forms/Services_Requiring_Prior_Auth.pdf or contact us at **1(415) 547-7818 ext. 7080**, or the UM department for the member’s delegated medical group (see **Appendix A**

for contact information) for the most up-to-date list of prior authorization requirements. All referrals to and services at providers outside of a member’s medical group (e.g., a SFHN member consulting with a UCSF specialist) or outside of the Plan (not contracted with SFHP) and inpatient admissions require authorization. Planned admissions require prior authorization and unplanned admissions are reviewed for authorization once SFHP is notified of the admission. Referrals within a member’s medical group do not require prior authorization. Please be sure to include a prior authorization number when applicable.

Corrected Claims

Claims denied or rejected for insufficient or incorrect claim data and/or for missing documentation, can be corrected and resubmitted for processing. If you are trying to replace a claim that has already been submitted, follow these steps to submit corrected claims:

- **CMS 1500 forms:** Place a “7” for corrected claims in Box 22 of the form and include the original Claim ID in Box 22 after the resubmission code. Placing the original claim ID will help automate the replacement process in our system
- **UB 04 forms:** Indicate a corrected claim with the appropriate bill type, XXX7 and place the original claim ID in field 64 (Document Control Number). Placing the original claim ID will help automate the replacement process in our system
- **To VOID a previously submitted claim:** Use an “8” in Box 22 of the CMS 1500 form or with the appropriate Bill Type, XXX8, on UB 04 forms

Corrected claims are considered a new billing and therefore must meet the Claims Timelines, as would an original claim.



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Please note the following:

Per CCR T22, Sections 51008: “resubmitted” claims must be received back from provider not later than 60 days following date of resubmission. See **CCR T22, Sections 51008 C & D:**

§ (c) A Resubmission Turnaround Document (RTD), which has been sent by the fiscal intermediary for correction or additional information, must be received back from the provider not later than 60 days following the date of the RTD. The claim is subject to denial of payment if corrections or additional information furnished by the provider on the RTD are incomplete, inaccurate, or untimely.

§ (d) A request for adjustment or reconsideration of an adjudicated claim must be received by the fiscal intermediary not later than six months following the date of payment or denial of the claim by the fiscal intermediary. If favorable resolution of a claim is not obtained, a grievance or complaint concerning the processing or payment of the claim must be filed in accordance with **Section 51015** (Billing procedures for claims delayed by good causes).

For EDI information **click here** or documentation can be found at the link below:

sfhp.org/providers/our-network/edi/

Health Insurance Claim (CMS 1500) Form Instructions



The most current and standard Center of Medicaid and Medicare Services (CMS) 1500 form must be used to bill SFHP for medical services. The form is used by Physicians and Allied Health Professionals to submit claims for

medical services. All items must be completed unless otherwise noted in the appendix for CMS1500 paper or electronic claim forms.

Health Insurance Claim Form (UB 04) Instructions



The UB 04 claim form is used to submit claims for inpatient and outpatient services by institutional facilities (for example, outpatient departments, Rural Health Clinics, chronic dialysis, and Community-Based Adult

Services). All fields must be completed unless otherwise noted in the appendix for UB paper or electronic claim forms.

See Appendix B for link to EDI information

NOTE: In order to maintain the highest level of data integrity, SFHP will not add or change any information on a submitted claim (electronic or paper), therefore, the entire claim may be rejected if any of the required data elements are missing or invalid.

Other Insurance / Coordination of Benefits

Some SFHP members have other health coverage (OHC) in addition to their SFHP coverage. Specific rules govern how benefits must be coordinated in these cases. For information on member eligibility and program descriptions, please see the Network Operation Manual on sfhp.org/providers/provider-resources/network-operational-manual.

State and Federal laws require that all available health coverage be exhausted before billing Medi-Cal. Thus, when a SFHP member has other health coverage and has Medi-Cal, SFHP will always be the payer of last resort.

Other Health Coverage (OHC) includes any non-Medi-Cal health coverage that provides or pays for health care services.



This can include:

- Healthy Workers HMO
- Commercial Health Plans (individual and group policies)
- Prepaid Health Plans
- Health Maintenance Organizations (HMO)
- Employee benefit plans
- Union Plans
- Tri-Care, Champ VA
- TPL – Third Party Liability
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (PPO, HMO, and Fee-for-Service) plans

When an SFHP member also has OHC, they must treat the other insurance plan as the primary insurance company and access services under the company's rules of coverage. SFHP is not liable for the cost of services for members with OHC who do not obtain the services in accordance with the rules of their primary insurance. If a member elects to seek services outside of the framework of his or her primary insurance, the member is responsible for the cost.

If other insurance is primary and SFHP does not pay as primary, procedures which normally require prior authorization will not be required except for the following services: admission for skilled nursing facilities, long term care facilities, and dialysis treatment.

To coordinate benefits for a patient who has dual coverage, you must bill the primary insurance first. If there is any balance remaining after payment is received from the primary insurer, you should submit a claim to SFHP or the appropriate Medical Group responsible along with the Explanation of Benefits (EOB) from the primary payer or the equivalent data in an electronic claim file. If your SFHP claim is denied for no EOB, you may resubmit the claim along with a copy of the EOB, if by paper, or include the

data in the electronic claim file. Please see **Claims Submission** section for more details.

SFHP follows the guidelines set by All Plan Letter (APL) 13-003 for all Other Health Coverage claims:

Managed Care Plans (MCP) are required to reimburse Medicare providers for Medi-Cal services that are not covered by Medicare and for all applicable Medicare deductibles and coinsurance, as long as collectively they do not exceed the maximum allowable Medi-Cal Fee-for-Service (FFS) reimbursement rates.

- San Francisco Health Plan reimburses Medicare and Medi-Cal eligible providers for applicable deductible and coinsurance, if the collective payment of Medicare and Medi-Cal does not exceed Medi-Cal's reimbursement rates; therefore an EOB or electronic equivalent must be submitted with claims

When a SFHP members' primary insurance has co-payments and/or deductibles, the member cannot be asked to pay, as long as he or she is obtaining benefits within the rules of the primary insurance. The exceptions to this are: 1) Healthy Workers HMO with timely filing; and 2) When the member has Medicare Part D.

It is important to note that the Healthy Workers HMO line of business is considered a commercial plan. Therefore, Healthy Workers HMO is primary over a member's Medicare and/or Medi-Cal coverages.

NOTE: Effective May of 2018, SFHP receives Medicare crossover claims automatically from CMS for our Medi-Cal lines of business only (not for other SFHP lines of business, like Healthy Workers HMO. Your EOB from Medicare should indicate that the claim was forwarded to SFHP or a Managed Healthcare Plan. SHFP refers to these as COBA claims.



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Third Party Liability

If a member is injured through the act or omission of another person (a third party), SFHP will, with respect to services required as a result of that injury, provide covered services to its members, but the member shall agree to the following:

- Agrees to reimburse SFHP the reasonable cash value of benefits provided as reflected by the physician's usual and customary charges and as allowed by law, immediately upon collection of damages by the member, whether by action at law, settlement, or otherwise
- Provides SFHP with a lien, in the amount of the reasonable cash value of Benefits provided by SFHP, as reflected by a percentage of the provider's usual billed charges but not exceeding the amount

actually paid by the Plan, as set forth in California Civil Code section 3040. The lien may be filed with the third party, the third party's agent, or the court. For Medi-Cal members, the State Department of Health Care Services (DHCS), and not SFHP, has the right to recovery and can ask a third party for money related to services obtained from SFHP

For more information on Medi-Cal Third Party Liability and Recovery, contact DHCS:

Department of Health Care Services
Third Party Liability and Recovery Division
Personal Injury Unit-MS 4720
PO Box 997425
Sacramento, CA 95899-7425
Phone: **1(916) 650-0490**
Fax: **1(916) 440-5668**
dhcs.ca.gov



Claims Coding

In the Claims Coding Section you will find coding requirements to assist you in billing correctly for services rendered to SFHP members.

Overview of Codes

San Francisco Health Plan uses Medi-Cal billing guidelines in addition to Optum coding books application for claim activities. Additional coding information and updates can be found on the AMA website at ama-assn.org.

The most current procedure codes valid on the date of service must be used for a claim to be processed:

- Professional charges – HIPAA compliant HCPCS Level 1 (CPT) & level 2
- Inpatient hospital/facility/institutional charges – UB 04 revenue codes
- Outpatient hospital/facility charges – HCPCS Level 1 & 2 codes
- HCPCS Level 3 codes until retired by DHCS

Professional and institutional charges must be submitted as separate claims. If submitted on the same claim, one or the other type of charges will not be considered for payment. For example, if professional charges (CPT codes) are included on an institutional claim for an inpatient stay, then these charges will be automatically bundled under the per diem payment.

The following includes special instructions regarding the use of various codes for different types of services. CPT codes, rather than HCPCS codes, should be used as first line coding when an appropriate code exists.

Professional

CPT-4	Professional Services
HCPCS I	Physician Services
HCPCS II	Non-Physician Procedures and Services
HCPCS III	California Only

Inpatient

Revenue Codes	Inpatient Facility Services
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CPT Codes

Report ambulatory surgery, outpatient department visits, diagnostic testing, and ancillary services using CPT, HCPCS Level II and III codes. Claims submitted with invalid, incorrect, or missing procedure codes will be denied.

Procedure	CPT or HCPCS
Surgery	10000–69999
Radiology	70000–79999
Pathology & Laboratory	80000–89999
Medicine	90281–99199
Evaluation & Management	99201–99499
Anesthesia	00001–10000



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Conflicts with Other Common Core Data

Claims are screened for conflicts with another patient and/or provider information. Reimbursement will not be made for claims where CPT procedure codes conflict with common core data, such as:

- Patient age/gender
- Diagnosis
- Place of service
- Provider specialty

Unlisted Services and Procedures

Claims for services submitted with unlisted CPT procedure codes (XXX99) require the following:

- Invoices of other pertinent information for DME, etc.
- Medical records for surgical procedures
- Documentation/Remarks or itemization of supplies
- Authorization

Age Parameters

Claims are processed according to the following age parameters as defined by Medi-Cal.

Age Range	Classification
Up to 17 years	Pediatric (infant, children, and adolescent) patients
18 years and older	Adult patients

Healthcare Common Procedure Coding System (HCPCS) Codes

The Healthcare Common Procedure Coding System (HCPCS) is a national, uniform coding structure developed by the Centers for Medicare & Medicaid Services (CMS) to standardize the coding systems used to process Medicare and Medicaid (Medi-Cal) claims on a national basis. HCPCS is a three-level coding system that incorporates Physicians' Current

Procedural Terminology (CPT-4), National, and Local codes.

The HCPCS coding format for Level I is five-digit numeric. The format for Level II and III is an alpha character followed by four numeric digits. The full range of codes for each level is as follows: Level I is 00100 thru 01999 and 10000 thru 99999; Level II is A0000 thru V9999.

The existence of a specific Level II HCPCS code for a particular item or service is not a guarantee that the item or service is covered by SFHP. Refer to the section in the Medi-Cal Provider Manual at medi-cal.ca.gov specific to the service rendered for Medi-Cal reimbursable Level II.

Diagnosis Codes

SFHP requires a valid diagnosis code with each claim. Claims submitted with invalid, incorrect, or missing diagnosis codes will be denied.

Diagnoses and procedures for inpatient admission and outpatient services should be coded using the International Classification of Diseases (ICD-10-CM or ICD-10-PCS). Use the appropriate diagnosis code(s) for which the patient presented. Please provide the most specific ICD-10 code, down to the sixth-character level if appropriate.

Claims are screened for conflicts with another patient and/or provider information. Reimbursement will not be made for claims where Diagnosis procedure codes conflict with common core data, such as:

- Patient age/gender
- CPT code
- Place of service
- Provider specialty

Modifiers

Modifiers are the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition



or code. Although many procedure codes require a modifier, some procedures do *not* need further clarification via a modifier. The inappropriate use of a modifier may result in the claim being denied.

We follow current approved HIPAA compliant modifiers and consult Medi-Cal guidelines for appropriate coding.

Multiple Procedures or Visits

In general, only one visit or consultation per specialty is reimbursed for the same date of service. When two or more visits/consultations are billed for the same date of service, appropriate modifiers should be used or claim notes should be made so they will be reviewed for individual consideration. Please ensure to use the appropriate member ID, rendering physician NPI (s), dates of service, service code(s), and modifiers when billing for more than one service on the same date of service.

Multiple surgery procedure codes (CPT 10000–69999) for the same patient, for the same date of service, are required to be coded following Medi-Cal guidelines. Add appropriate modifier to indicate two or more visits/consultations.

When a service is legitimately rendered more than once on the same date of the service (before and after X-rays, glucose tolerance testing, ova and parasite tests, etc.), providers must include documentation with the claim explaining why the service was rendered more than once. This information may be entered in the *Reserved for Local Use* field (Box 19) or on an attachment to the claim. When billing electronically, enter the statement in the *Remarks* area. Include the rendering physician's NPI number in box 24I. A statement indicating, "this service is not a duplicate" is not sufficient to clarify why the service was rendered more than once.

For more information on duplicate billing, see page 19.

By Report Service / HCPCS Codes

This section includes information about "By Report" procedures, attachments, and documentation. The following applicable information must be included in either Box 19 of the CMS 1500, Box 84 on the UB 04 form, or provided as an attachment to the claim form:

- Invoice should include item description, manufacturer name, model number, catalog number, manufacturer suggested retail price (MSRP), if applicable.
- Operative report, operating time or procedure report including a description of the actual procedure performed and the results of the procedure.
- Number, size, and location of lesions (if applicable).
- Time involved, the nature and purpose of the procedure or service, and how it relates to the diagnosis. Description of and justification for any special features, custom modifications, etc.
- The reason a listed code was not used. Itemization of miscellaneous supply codes, etc.

National Drug Codes (NDC) and Unique Product Numbers (UPN)

National Drug Code (NDC):

The Federal Deficit Reduction Act of 2005 (DRA) requires Medi-Cal to collect rebates from drug manufacturers for physician-administered drugs. The collection of rebates is accomplished with the inclusion of National Drug Codes (NDCs) on claims submitted by providers.

Providers must use NDC for physician-administered drugs, in conjunction with the customary Healthcare Common Procedure Coding System (HCPCS) Level



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I, II, or III code, as well as a valid NDC number, the quantity, a unit of measure (UOM), on all Medi-Cal claims. Claims will be denied if providers do not submit claims with a valid NDC or NDC/HCPCS combination codes as mandated by the NDC reporting requirement.

Physician-administered drugs include any covered outpatient drug billed by a provider other than a pharmacy. This includes (but is not limited to) the following provider types:

- Physicians
- Clinics
- Hospitals

The NDC reporting requirement applies to claims submitted using the following formats:

- 837 electronic transactions for Institutional and Professional claims
- CMS 1500 and UB-04 paper claims

Unique Product Number (UPN):

There are codes that require a UPN, see Medi-Cal guidelines for the list of those codes, **medi-cal.ca.gov**. Claims must be billed with a HCPC and correct UPN for reimbursement.



Claims Requirements and Policies

This section was developed to assist you in understanding key claim requirements and policies.

Professional Services

SFHP reimburses providers for professional services. Professional services should be obtained within the member's network. Most professional services rendered outside of the member's network require prior-authorization. Emergency services, Family Planning, and Sensitive Services do not require prior authorization. Professional services should be billed on a CMS 1500 claim form and should be submitted to the Member's Medical group or SFHP as referenced in **Appendix A**.

Gynecological and OB Services

SFHP members may access obstetric and gynecological services directly from an OB/GYN specialist or family practitioner within the member's medical group without a referral. Services rendered by providers outside of the member's medical group or outside the Plan require prior authorization. This includes all services provided by an OB/GYN, including prenatal and Comprehensive Perinatal Services Program (CPSP) services.

The Comprehensive Perinatal Services Program (CPSP) offers a wide range of services to pregnant Medi-Cal SFHP members from the date of conception through 60 days after the month of delivery. Member and provider participation is voluntary. Providers must have a current provider number and complete an

application to participate as a CPSP provider. CPSP codes can be used by CPSP certified providers only.

SFHP does not allow Global Billing for Obstetrical Services. OB services should be billed on a per-visit basis.

Additional information regarding CPSP, obstetric, and gynecological billing can be found at medi-cal.ca.gov and cdph.ca.gov or see **Appendix B** for information.

Anesthesia

SFHP reimburses anesthesia services to providers for induction of general or regional anesthesia and supportive services associated with the provision of optimal anesthesia care for medical or surgical procedures.

SFHP reimburses anesthesia services using the Anesthesia Unit System. SFHP requires the following for Anesthesia billing:

- Services are reimbursed using the surgical CPT code or anesthesia codes. Complete the CMS 1500 form using the surgical anesthesia services CPT code representing the major procedure performed with the appropriate HCPCS anesthesia modifier



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- If an unlisted (not otherwise specified) CPT code is used, submit documentation of the operative procedure with the claim
- Services are reimbursed by determining the sum of the allowable base and time units
 - Base values as defined by the American Society of Anesthesiologists (ASA); SFHP automatically assigns base values from Medi-Cal fee schedule
- A time unit of fifteen (15) minutes or a portion thereof. Each 15-minute increment equals one unit.
 - Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can be safely placed under post-operative supervision
 - Enter the number of 15 minute increments of anesthesia time in the Service Units/Days box (24G). The last anesthesia time increment rendered may be rounded to a whole unit if it equals or exceeds five minutes, it may not be billed as an additional anesthesia time unit
- Submit paper claims with the elapsed time in minutes

- Some laboratory and pathology consultant opinions, when the test results are outside the normal or expected range and the ordering physician requests additional outside testing

SFHP does not reimburse:

- Specimen collection or venipuncture charges made in conjunction with laboratory services or evaluation and management services are not reimbursable

Billing:

- Complete the CMS 1500 form using appropriate CPT and HCPCS codes for laboratory and pathology services performed in a non-institutional setting
- Bill using the appropriate modifiers for the services rendered

Laboratory and Pathology

SFHP reimburses technical, professional laboratory, and pathology services when rendered by a contracted provider at approved clinical and diagnostic laboratories or when authorized by SFHP or delegated medical group.

SFHP reimburses:

- Panel codes when all individual tests included in the panel have been performed
- Individual codes when all components in a panel have not been performed
- Clinical laboratory tests, when performed by a technician under physician

Ambulance Transport

SFHP reimburses licensed ambulance companies for emergency transportation, without an authorization required, and can include other necessary services such as mileage and ECG. The claim must contain the emergency Place of Service code on the claim form. For non-emergency transportation from residence to facility, or to dialysis, a prior authorization is required. Note: A prior authorization is not required for non-emergency transportation from facility to facility/residence. See **Appendix B** for links to additional information.

NOTE: Please see sfhp.org/files/providers/forms/Services_Requiring_Prior_Auth.pdf or contact the UM department for the delegated group (see **Appendix A**) or call SFHP UM department at **1(415) 547-7818 ext. 7080** for the most up-to-date information, including the necessary modifiers.

Vision Services

SFHP will reimburse medically-indicated vision service rendered to SFHP members. Please visit



sfhp.org to determine if a prior authorization for medically-indicated vision services is required. All other vision-related services should be billed directly to Vision Service Plan (VSP).

Additional billing information is available directly from Vision Service Plan (VSP) by calling **1(800) 216-6248**.

Inpatient Services

SFHP reimburses inpatient care, subject to authorization and notification requirements.

Authorizations are based on medical necessity and covered services, contingent upon a member's eligibility, and are not a guarantee of payment. The provider is responsible for verifying a member's eligibility on the dates of services.

For members assigned to the UCSF medical group, please submit an authorization request for inpatient admission within 24 hours or by 5:00pm the next business day. To submit an authorization request for inpatient admissions, please fax a facesheet to **1(415) 547-7822**. Authorization requests for Inpatient Admissions are processed via Expedited Concurrent Review. If you have additional questions, please contact SFHP UM Department at **1(415) 547-7818 ext. 7080**.

For members assigned to SFN and CLN, please submit an authorization request for inpatient admission within 24 hours or by 5:00pm the next business day if the member is admitted to any hospital except Zuckerberg San Francisco General Hospital and Trauma Center. An authorization is NOT required for emergency pre-stabilization services delivered in an emergency department or ambulance setting.

SFHP requires non-contracted hospitals to notify SFHP within 24 hours, or, if the notification period ends on a weekend or holiday, by 5:00pm the next business day. SFHP does not deny authorization requests for medically necessary post-stabilization services. If SFHP is notified after the 24 hour or next

business day period, while the patient is still hospitalized, SFHP may deny non-medically necessary care from the point SFHP is able to assume responsibility of care or transfer member to a contracted hospital. Any claim submitted by a non-contracted hospital is subject to a retrospective review and audit for medical necessity and appropriate billing.

SFHP does reimburse for authorized Administrative Days when correct Revenue Codes are used per Medi-Cal guidelines and rates.

Admission Date

The admission date determines all inpatient reimbursement terms. When admission dates bridge contract effective dates, the contracted rate will be applied to those dates on or after the contract effective date.

Determination of inpatient status occurs at the date and time the admitting physician writes the order to admit the member to inpatient status and when the member's clinical status meets SFHP's criteria for inpatient care.

Membership Date

No reimbursement will be made after a SFHP member terminates membership with the San Francisco Health Plan, even if the member is an inpatient in the hospital on the date of termination.

SFHP reimburses inpatient care (except for Organ Tissue Procurement and Factor 8) based on the Medi-Cal APRDRG pricing methodology when prior authorization is approved and when notified within appropriate timeframes. All services provided within 24 hours of an inpatient admission that are related to the principal diagnosis are included in the inpatient per diem reimbursement. Reimbursement includes:

- Operating room services
- Recovery room services
- Ancillary services
- Room and board



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- Nursing care
- Supplies and therapeutic items (drugs and biologicals)
- Appliances and equipment
- Diagnostic services

SFHP does not separately reimburse:

- Blood or blood products associated with surgery
- Personal services, telephone calls, televisions, and guest trays

Billing

Complete the Electronic Data Information (EDI) 837 Institutional claim file or UB04 claim form using the appropriate inpatient services revenue codes and diagnosis codes. All professional services should be billed within an EDI 837 Professional claim file or on a CMS 1500 claim form using the appropriate CPT/HCPCS and diagnosis codes.

Compensation Conditions

Compensation shall be on a fee-for-service basis; providers shall be paid the rates pursuant to the Medical Group contract or negotiated rate. Reimbursement shall be based exclusively on medically necessary services and authorization. One per diem is payable for each:

- Member who occupies a bed in the hospital at 12:00am midnight
- Member admitted and discharged during the same day, provided that such admission and discharge are not within 24 hours of a prior discharge
- Mother and newborn child (children) when both mother and newborn child (children) are in the hospital on the same day, unless the child (children) is in the neonatal intensive care unit

NOTE: All Inpatient claims received at SFHP are paid based on Medi-Cal's APRDRG pricing methodology.

Facility Outpatient Billing

Prior notification by the hospital to SFHP or the designated Medical Groups is required for all facility outpatient services.

Complete the EDI 837 Institutional claim file or UB 04 claim form using the appropriate outpatient facility HCPCS codes and diagnosis codes. If applicable, enter the authorization number in box 63.

Professional services should be billed within an EDI 837 Professional claim file or on a CMS 1500 claim form using the appropriate CPT/HCPCS and diagnosis codes.

Medical Supply Billing Requirements

Please submit medical supply claims as a paper claim via mail. The medical supply billing requirements, impact Durable Medical Equipment (DME) and Pharmacy providers, include:

- HCPCS Level II codes are required for all disposable and incontinence medical supplies
- A Universal Product Number (UPN) is required for all contracted items
- Only product identification numbers listed in the Medi-Cal provider manual under "UPN" will be acceptable for billing purposes
- Invoice should include item description, manufacturer name, model number, catalog number, manufacturer suggested retail price (MSRP), if applicable, and any taxes paid for reimbursement purposes based on Medi-Cal's taxable codes table
- Itemization of miscellaneous supply codes, etc

Emergency Room Services

SFHP reimburses emergency room (ER) services when a member reasonably believes an



emergency/urgent-emergent medical condition exists and that this belief is reasonable given the member's age, personality, education, background, and other similar factors.

ER care is reimbursed on a fee-for-service basis and includes all facility services directly related to the services provided as part of the emergency room care (i.e., transportation pharmacy, ancillary, and supplies).

ER care is a covered benefit, regardless of network. The member's emergency room co-payment is waived when emergency care results in an inpatient admission. Emergency care that precedes an inpatient admission is included in the contracted inpatient payment rate and terms.

Complete the EDI 837 Institutional claim file or UB 04 claim form using the appropriate Revenue Codes representing the emergency room facility charges. Complete the EDI 837 Professional claim file or CMS 1500 claim form using the appropriate Place of Service (POS) code representing that the professional services were rendered in the emergency room facility. All surgical procedures performed in the emergency room must be billed using the appropriate CPT and HCPCS codes. For more information on where to submit emergency room service claims, please see **Claims Contact Information**.

For EDI information **click here** or documentation can be found at the link below:
sfhp.org/providers/our-network/edi/

Immunizations

Federal Vaccines for Children (VFC)

The Federal Vaccines for Children (VFC) program supplies free vaccines to Medi-Cal enrolled physicians. Every Medi-Cal-eligible child younger than 19 years of age may receive vaccines supplied by the VFC program. To participate, providers must enroll in VFC even if already enrolled with Medi-Cal or

the Child Health and Disability Prevention (CHDP) Program. Immunization services must be billed using the appropriate CPT code. For additional information regarding VFC please refer to **medi-cal.ca.gov** for the most up-to-date information.

CPT Codes with Modifier-SL (State Supplied Vaccine)

Providers must use a VFC-provided vaccine when available, and use modifier-SL with the CPT code to bill for these immunizations. VFC providers who bill modifier-SL with the CPT codes will be reimbursed only the Medi-Cal VFC program administration fee.

NOTE: Medi-Cal providers who are not VFC providers cannot use modifier-SL because this service is available only for VFC providers.

Providers are required to bill using a modifier-SK with the CPT-4 codes if the recipient is at high risk for the disease or condition for which the immune globulin/vaccines/toxoid is given. Providers are required to document in the recipient's medical record the medical reason why the recipient is "high risk" for the disease or condition for which the injection was administered. Providers are no longer required to submit the reason for high risk on the claim, but must do so on the medical record. Please refer to: **medi-cal.ca.gov** for additional information.

Non VFC Vaccines

Healthy Workers HMO members do not qualify for the VFC program. Please send your claims to SFHP.

For Medi-Cal SFHP will cover some vaccine serums that do not fall under VFC either administered by the PCP or rendered in the ER, see Medi-Cal guidelines for specific reimbursement information.

Duplicate Billings

Identical services billed for the same date of service are considered duplicate billings, and only one service will be reimbursed. SFHP uses the following



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fields to identify Provider rendering services duplicate billing: member ID, dates of service, service codes, and modifiers. If you are billing for multiple procedures or visits on the same date of service, ensure to include the appropriate modifiers, rendering provider NPI, and supporting documentation. For more information on how to bill for multiple procedures or visits, see the **Multiple Procedures or Visits** section. If you feel your claim was incorrectly denied for duplication, please contact Provider Relations, provider.relations@sfhp.org, who will research the claim denial.

SFHP Covered Benefits

For the most up-to-date information on covered benefits, by line of business, refer to the Evidence of Coverage available at sfhp.org.

Services Covered by Other Entities

When a member qualifies for services that are carved out of the Plan coverage and may be covered through another entity, San Francisco Health Plan requires the remittance advice from the other entity before considering reimbursement. Examples of these entities include, but are not limited to:

- Non-Specialty Mental Health and Behavioral Health Treatment (BHT)-covered by Beacon Health Strategies
- California Children’s Services — Services are reimbursed through CCS
- Golden Gate Regional Center
- Dental Services — Services provided through Denti-Cal
- Vision Services, including refraction – Service are reimbursed through VSP
- Most Major Organ transplants — Members are disenrolled to Fee-for-Service Medi-Cal
- Long Term Care (LTC) – SFHP covers the month of and the month following admission;

members are then disenrolled to Fee-for-Service Medi-Cal

- Specialty and Inpatient Mental health services — services provided through SF County Mental Health

Below is the contact information for services covered by other entities by Lines of Business:

Medi-Cal

Non-Specialty Mental Health **Beacon Health Strategies**
 Members Line: **1(855) 371-8117**
 Website: provider.beaconhs.com

Autism Services **Beacon Autism Services Group**
1(855) 834-5654

Specialty Mental Health **San Francisco Behavioral Health Services**
1(888) 246-3333

***Providers can use screening tool to help assess if NSMH or SMH**

Vision **VSP**
1(800) 877-7195

Dental **Denti-Cal**
 Members:
1(800) 322-6384
 Providers:
1(800) 423-0507

HealthyWorkers HMOSM

IHSS Employee Questions **1(415) 243-4477**

Specialty Mental Health **San Francisco Behavioral Health Services**
1(888) 246-3333

Vision **VSP**
1(800) 877-7195



Dental	Liberty Dental 1(888) 703-6999
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Medicare

Medicare	1(800) 633-4227
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Medicare HMO Payment	1(866) 227-9863
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Medicare for Providers	1(916) 650-6552
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- Diagnosis and treatment of sexually transmitted diseases
- Sterilization
- Abortion
- Follow up care for complications associated with contraceptive methods provided or prescribed
- Screening, testing, and counseling for HIV; and
- Pregnancy testing and counseling

Prior Authorization requirement is waived for basic prenatal care, OB/GYNs, and family medicine providers for routine and preventive care, preventive services, and a number of other services. However, these services must be received within medical group.

For sterilization services, the PM 330 consent form is required to process the claim for payment. Please attach the consent form to the claim and submit through the mail.

Healthy Workers HMO members are required to obtain all services from within the member's designated provider group and prior authorization may be required. You can find the most up-to-date prior authorization requirements on our website, under Providers at sfhp.org.

Family Planning, Sensitive Services, and Diagnosis

For Medi-Cal members, prior authorization is not required for emergency services and family planning services, regardless of where services are received. Family Planning services are services to temporarily or permanently prevent or delay pregnancy and maintain sexual health, including, but not limited to:

- Contraceptive pills, devices, and supplies, including health education and counseling, to make informed choices regarding contraceptives
- Physical examinations related to family planning
- Laboratory tests related to decision-making process for choice of contraceptive management



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Claim Status, Reconsiderations, Recoveries, and Denials

This section will provide you with steps to take if you need information on an open claim and how to request a review on a denied claim.

Claims Status Requests

Inquiries regarding claims, including “tracers”, are welcome sixty (60) days after the initial claims submission. Duplicate claims submitted prior to sixty (60) days may cause delays in processing your claims. Claim status can be checked through the **Provider Portal** on our website at sfhp.org. Providers may contact the SFHP Claims department at **1(415) 547-7818 ext. 7115** or claims@sfhp.org to discuss concerns regarding claims submissions.

A request for reconsideration of the claim must be submitted within one (1) year from the date of the Remittance Advice (RA) on which the claim appeared as denied. Any errors on the original claim should be corrected at this time. Timeliness limits will apply if the appropriate follow-up time is not acknowledged. If it is determined that the claim was handled correctly based on the information and documentation received by SFHP, the provider will be advised of the proper procedure for further claim dispute. See **Appendix B** for link to grievance information for SFHP.

Notice of Action Letters for Member Denials

San Francisco Health Plan and its delegated medical groups are responsible for notifying Medi-Cal and Healthy Workers HMO members of denials of payment on emergency and family planning claims. A Notice of Action letter is sent to the member on each emergency and family planning claim that is denied. The Notice of Action letter informs the member of a claim denial, including the reason for the denial and informs the member of their appeal rights.

Claim Recoveries

As a provider of Medi-Cal health care services and as a Knox-Keene licensed health care services plan for Medi-Cal and Healthy Workers HMO, SFHP follows State guidelines and regulations to provide quality and cost-effective service delivery to our members and providers. SFHP also follows guidelines set forth in the **California Code of Regulations, Title 22, Sections 50761, 53866**, to prove fiscal prudence and payment accuracy in reimbursements made to providers for services rendered.



When an overpayment is identified, either by San Francisco Health Plan or the provider's business office, we will recover the payments that were made in error by requesting via written request that the provider either issue a lump sum refund check payable to San Francisco Health Plan or authorize recoupment against future claims for the overpaid amount. Mail refund check or authorization to recoup to:

Authorization to recoup:

San Francisco Health Plan
Attention: Claims
PO Box 194247
San Francisco, CA 94119

Refunds:

San Francisco Health Plan
Attention: Finance
PO Box 194247
San Francisco, CA 94119

Per the letter sent to the Provider, SFHP requests the following information be provided with any overpayments submitted to SFHP:

- SFHP Member ID
- SFHP Member Date of Birth
- SFHP Claim ID(s)
- Overpayment Reason
- Primary Payer EOB, if applicable

In the situation where a letter was sent to the Provider regarding an overpayment, if no response is received by 30 days of issuance, the amount will be recouped against future claims.

If the Provider feels that a recovery of an overpayment initiated by SFHP was in error or if the Provider disagrees with the recovery of an overpayment, the Provider may file a dispute, see **Provider Dispute Resolution** section.

Provider Dispute Resolutions (PDR)

SFHP offers a fair and cost-effective dispute resolution process to providers who are dissatisfied with a claim, billing, or contract decision. A Provider Dispute Resolution Request must be submitted in writing using the Provider Dispute Resolution Request Form, or by letter, clearly identifying what is being disputed and the expected outcome. Dispute requests must be submitted within 365 days of SFHP's most recent action regarding the disputed claim.

SFHP recommends that the following information be submitted with all dispute requests to help expedite the resolution process:

- A Complete SFHP Provider Dispute Resolution Request Form (Available on SFHP's website, sfhp.org/providers/provider-forms/provider-disputes/).
- SFHP Original Claim Number
- SFHP Member ID Number
- Reason for the dispute
- Applicable documentation, such as Medical Records, EOB, or Invoices.
- Contact name and Address for return correspondence

If SFHP does not receive enough information to identify the claim that is being disputed or to make a determination, an Amended Dispute may be requested. In order to ensure that a dispute is processed as quickly as possible, please submit all necessary information and documentation that may affect the outcome of the dispute as soon as possible.

Disputes must be submitted in writing to the following address:

San Francisco Health Plan
Attention: Claims
PO Box 194247
San Francisco, CA 94119



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SFHP will issue a written letter acknowledging the receipt of the dispute within 15 business days of the dispute's receipt. A written determination letter will be issued within 45 business days after receipt of the dispute.

SFHP recommends contacting our Claims or Provider Relations Departments before submitting a formal dispute, as some issues may be resolved over the phone. Please refer to **Appendix A** for contact information.

Balance Billing

Participating providers are prohibited from balance billing any member for covered services on all lines of business, except Healthy Workers HMO, for which SFHP is financially responsible. However, other than specific requirements under Medi-Cal for dual eligibles, SFHP is not financially responsible for co-payments; therefore providers may bill the member for a co-payment.

San Francisco Health Plan complies with **California Code of Regulations, Title 22, section 53866**, which allows members to be balanced billed if they refuse to consent to be transferred to their home hospital for post-stabilization care. Please contact SFHP Utilization Management Department at **1(415) 547-7818 ext. 7080** to discuss discharge planning prior to balance billing a SFHP member for this purpose.

Fraud, Waste, and Abuse

Health care fraud is defined as an intentional deception or misrepresentation that an individual or entity makes knowing that the deception or misrepresentation could result in some unauthorized benefit to the individual, entity, or some other party. Medi-Cal considers fraud to be “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in

some unauthorized benefit to himself or some other person.” Abuse may also result in unauthorized payments or benefits, but is considered to have occurred without the intent.

Common types of fraud within managed care include submission of false claims for services not performed, or for services different than those performed, denial of medically necessary services, deceptive enrollment practices, and receipt of services an individual is not entitled to receive.

If you suspect any fraud, waste, or abuse, please contact San Francisco Health Plan's Compliance Department at:

- Compliance hotline at: **1(800) 461-9330** or online at **convercent.com/report**
- Compliance Officer at: **1(415) 615-4217** or
- Email: **compliance@sfhp.org**

Claims Department

If there is suspected fraud, the SFHP Compliance Officer and representatives from the Claims department will follow proper procedures, using an established auditing tool, to investigate the suspected fraud and take corrective action. The Compliance Officer will keep a written record of all random audits performed on claims and any employee reports of non-compliance or fraudulent provider conduct.

Compliance Department

The Compliance Department is responsible for the Compliance Program and related policies and procedures. The Compliance Officer is responsible for investigating all allegations for fraud, privacy, and security breaches, and working in collaboration with other SFHP departments. If necessary, the Compliance Officer submits the mandated reports regarding breaches, fraud, and abuse cases to State and Federal agencies.





Appendix A

SFHP Contact Information






Questions About	Who to Call?	Tools to Use
Member Eligibility	Customer Service 1(800) 288-5555 or 1(415) 547-7800	Provider Portal sfhp.org Interactive Voice Response 1(415) 547-7810
Authorizations	Utilization Management Department 1(415) 547-7818 ext. 7080	Provider Portal sfhp.org
Claims	Claims Department 1(415) 547-7818 ext. 7115	Provider Portal sfhp.org
Provider Portal	Provider Relations 1(415) 547-7818 ext. 7084	provider.relations@sfhp.org
Provider Disputes	Claims Department 1(415) 547-7818 ext. 7115	
Authorization Appeals	Customer Service 1(800) 288-5555 or 1(415) 547-7800	
Remittance Advice	Claims Department 1(415) 547-7818 ext. 7115	Provider Portal sfhp.org
Privacy and Security Breaches	Compliance Department 1(415) 615-4217	Compliance@sfhp.org
Potential Fraud, Waste, and Abuse	Compliance Department 1(800) 461-9330	Convercent.com/report



Medical Group Prior Authorization and Claims Matrix

Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
BTP 	Professional: BTP Phone 1(415) 972-6000 Mail claims to: BTP Claims PO Box 72710 Oakland, CA 94612- 8910 Facility & DME: SFHP Phone 1(415) 547-7818 ext. 7115 Mail claims to: SFHP Claims PO Box 194247 San Francisco, CA 94119	All UM decisions: BTP Phone 1(415) 972-6002 Fax 1(415) 972-6011	1(415) 547-7800
CCHCA 	Professional, Non-Emergency Transportation: NEMS MSO Phone 1(415) 352-5186, option 2 Fax 1(866) 930-2290 Mail claims to: CCHCA Claims Department PO Box 2118 San Leandro, CA 94577 Facility, DME, Emergency Transportation: CCHP Phone 1(415) 955-8800 Fax 1(415) 955-8812 Mail claims to: CCHP Claims 445 Grant Ave, Suite 700 San Francisco, CA 94108	All UM decisions: NEMS MSO Phone 1(415) 352-5186, option 1 Fax 1(415) 398-2895	1(415) 547-7800







Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
SFN CLN  	All claims: SFHP Phone 1(415) 547-7818 ext. 7115 Mail claims to: SFHP Claims PO Box 194247 San Francisco, CA 94119	All UM decisions: SFHP Phone 1(415) 547-7818 ext. 400 Outpatient Fax: 1(415) 357-1292 Inpatient Fax: 1(415) 547-7822	1(415) 547-7800
HILL 	Professional: HILL Phone 1(800) 445-5747 Mail claims to: Hill Claims PO Box 8001 Park Ridge, IL 60068 Facility & DME: SFHP Phone 1(415) 547-7818 ext. 7115 Mail claims to: SFHP Claims PO Box 194247 San Francisco, CA 94119	All UM decisions: HILL Phone 1(800) 445-5747 UM/Authorizations Fax: 1(925) 820-4311 Inpatient Face Sheets: 1(925) 362-6577	1(415) 547-7800
JAD 	All Claims: CCHP Phone 1(415) 955-8800 Fax 1(415) 955-8812 Mail claims to: CCHP Claims 445 Grant Ave, Suite 700 San Francisco, CA 94108	All UM Decisions: CCHP Phone 1(877) 208-4959 Fax 1(415) 398-3669	1(415) 547-7800
KSR 	All claims: Kaiser Member Services 1(800) 390-3510 Mail claims to: Kaiser Claims 2425 Geary Blvd San Francisco, CA 94115	All UM decisions: Kaiser Phone 1(415) 833-2801 Fax 1(415) 833-2657	1(800) 464-4000



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Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
NEMS 	All claims: NEMS MSO Phone 1(415) 352-5186, Option 2 Fax 1(866) 930-2290 Mail claims to: NEMS MSO 2171 Junipero Serra Blvd, Suite 600 Daly City, CA 94014	All UM decisions: NEMS MSO Phone 1(415) 352-5186, Option 1 Fax 1(415) 398-2895	1(415) 547-7800
NMS (NEMS with SFHN)  	All claims: NEMS MSO Phone 1(415) 352-5186, Option 2 Fax 1(866) 930-2290 Mail claims to: NEMS MSO 2171 Junipero Serra Blvd, Suite 600 Daly City, CA 94014	All UM decisions: NEMS MSO Phone 1(415) 352-5186, Option 1 Fax 1(415) 398-2895	1(415) 547-7800
UCS 	All claims: SFHP Phone 1(415) 547-7818 ext. 7115 Mail claims to: SFHP Claims PO Box 194247 San Francisco, CA 94119	All UM decisions: SFHP Phone 1(415) 547-7818 ext. 400 Outpatient Fax: 1(415) 357-1292 Inpatient Fax: 1(415) 547-7822	1(415) 547-7800

Non-Specialty Mental Health Benefit Managed by Beacon Health Strategies

All Networks except Kaiser	All claims: Beacon Phone 1(855) 371-8117 Mail claims to: Beacon Claims 5665 Plaza Drive, Suite 400 Cypress, CA 90630	All screening/UM: Beacon Phone 1(855) 371-8117 Fax: 1(866) 422-3413	1(855) 371-8117
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Appendix B

Links to SFHP and Other Documents and Instructions

SFHP Main Website

sfhp.org

Appeals

sfhp.org/providers/authorizations/appeals/

Claims PreAuth

[sfhp.org/files/providers/forms/
Services_Requiring_Prior_Auth.pdf](http://sfhp.org/files/providers/forms/Services_Requiring_Prior_Auth.pdf)

EDI

sfhp.org/providers/our-network/edi/

Grievance

sfhp.org/about-us/grievance-info/

Network Operations Manual

[sfhp.org/providers/provider-resources/
network-operational-manual](http://sfhp.org/providers/provider-resources/network-operational-manual)

Provider Disputes

sfhp.org/providers/provider-forms/provider-disputes/

Medi-Cal

medi-cal.ca.gov

AMA Website

ama-assn.org

California Department of Public Health

cdph.ca.gov

CCR T22

Sections 51008 C & D
Section 51015



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Revision Log

Date	Section	Changes
Dec 2018	TOC	Reformatted
	Complete Document	Removed outline style and reformatted
	Claims Submission and Processing	Claims contact information moved to Appendix A
	Claims Submission and Processing	Moved Corrected Claims subsection to Clean Claims section to improve document flow
	Appendix A	Contact information moved to appendix section this includes other than SFHP contact information
	Appendix B	CMS 1500 with process steps moved from document body to appendix section
	Appendix C	UB 04 with process steps moved from document body
	Revision Log	Added to end of document
Jan 2019	Introduction	Verified Contracts information is correct
	Appendix A/ Contact Info Other Than SFHP	Replaced with current information from NOM
Feb 2019	Appendix C	Removed
	Appendix B	Revised to be links to external sourcing
Aug 2019	ALL	Formatting and re-write
Mar 2021	Claims Submission and Processing	Interest and Penalties section added

