



Provider Newsletter



October 2026

UPDATES INCLUDE:

- **Help Prevent Claim Delays with Accurate NPIs**
- **Claims Editing Enhancements** – Effective October 1, 2026
- **Targeted Rate Increase Payments Begin in October**
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- **Pharmacy-** Updated Guidance for the Treatment of Dyslipidemia
- **Facility Site Review Provider Pearl - Vaccine & Immunization Guidance:** Preparing for Fall and Beyond

Help Prevent Claim Delays with Accurate NPIs

Using the correct rendering and billing National Provider Identifier (NPI) helps prevent claim delays, denials, and compliance issues. Providers should review claim forms regularly to confirm that each NPI field reflects the appropriate provider or organization.

Know Which NPI to Use

Solo practitioners must use their own (Type 1) NPI. Group practices and organizations that conduct HIPAA standard transactions must use a unique organizational (Type 2) NPI.

Do not use an individual practitioner's NPI as the organization's NPI, even if the individual is the CEO, supervising physician, or another provider in the practice.

Rendering vs. Billing NPI

- **Rendering NPI:** Identifies the provider or organization that performed or supervised the service.
- **Billing NPI:** Identifies the pay-to provider or organization responsible for billing.

Why Accuracy Matters

SFHP and other payors use NPIs to verify who performed the service, who is billing, and whether the provider is appropriately credentialed. Incorrect or mismatched NPIs can lead to claim rejections, payment delays, audit findings, or additional review.

Common Errors to Avoid

- Using the billing NPI in place of the rendering NPI, or vice versa;
- Submitting an NPI for a provider who is not credentialed with the payor;
- Using an individual NPI as the organization NPI;
- Using outdated NPIs after name, location, taxonomy, or roster changes.

Quick Provider Checklist

- Keep provider and organizational NPI rosters up to date;
- Validate NPI information in NPPES at least annually;

- Verify NPIs during onboarding, credentialing, and roster updates;
- Confirm EHR and billing systems map NPIs correctly before claims are submitted.

Taking a few minutes to verify NPI information before submitting claims can help reduce avoidable follow-up and support timely reimbursement.

Claims Editing Enhancements – Effective October 1, 2026

San Francisco Health Plan (SFHP) will be implementing certain additional coding edits within the claims adjudication process effective **October 1, 2026**.

These enhancements are intended to support accurate claims payment by ensuring claims are processed in accordance with applicable coding and billing requirements and improve encounter acceptance.

Claims Edits Included

The first three claims editing enhancements scheduled for implementation are:

- **Medicaid Medically Unlikely Edits (MUE)** – Identifies claim lines where the number of units billed exceeds what is considered medically reasonable.
- **Medicaid National Correct Coding Initiative (NCCI) Unbundling** – Identifies services that are already included in another billed procedure.
- **Incontinence Medical Supply Frequency** – Identifies supply quantities that exceed applicable frequency limits.

The next claims editing enhancements queued for implementation are:

- **Interim Claims with Frequency Code 2 or 3** – Identifies inpatient claims requiring the appropriate discharge status code.
- **CA Facility Inpatient Invalid Patient Discharge Status** – Identifies inpatient claims with missing or invalid discharge status information.

- **Missing or Invalid Admission Date** – Identifies inpatient or long-term care claims with missing or invalid admission information.
- **Unacceptable Principal Diagnosis ICD-10** – Identifies claims with an invalid or unacceptable principal diagnosis.
- **Chemotherapy Epcoritamab-bysp Diagnosis** – Identifies applicable chemotherapy claims that are missing the required diagnosis.
- **Ophthalmology Codes Requiring Modifier** – Identifies applicable facility claims that require the appropriate modifier.

What Providers Need to Know

Beginning **October 1, 2026**, claims identified by these edits may require correction before payment can be made. Providers should continue to submit claims in accordance with applicable Medi-Cal coding, billing, and documentation requirements.

If a claim is impacted by one of these edits, providers should review the applicable claim or remittance information and, when appropriate, submit a corrected claim.

Providers are encouraged to review their current billing practices to help ensure claims contain accurate and complete information.

Questions

SFHP recognizes that changes to claim processing may result in questions. Providers are encouraged to contact SFHP with any questions regarding these claims editing enhancements. Please contact your assigned network manager. If you don't know who your network manager is, please email provider.relations@sfhp.org

Targeted Rate Increases Payments Begin in October

What providers need to know about APL 25-012

The California Department of Health Care Services (DHCS) issued [All Plan Letter](#)

[\(APL\) 25-012](#) with updated payment requirements for Medi-Cal Targeted Rate Increases (TRI). TRI applies to eligible primary care, obstetric, and non-specialty mental health services for dates of service on or after January 1, 2024.

The updated guidance also applies to certain services billed or rendered by eligible out-of-network providers, including family planning services, sexually transmitted disease services, HIV testing and counseling, and Minor Consent Services.

Who May Be Eligible

TRI Fee Schedule rates may apply to eligible procedure codes billed and rendered by certain provider types. Please refer to page 2 of [APL 25-012](#) for the list of provider types.

Payment Information

Beginning in October 2026, fee-for-service providers will receive retrospective payments for eligible codes with dates of service on or after January 1, 2024. New eligible claims processed in October 2026 and afterward will be paid at the contracted rate or the applicable TRI rate, whichever is higher. Payments will be issued through the usual claims payment process.

Depending on the procedure code, the TRI rate may include a 39.7% payment augmentation for specified physician services provided to members eligible for California Children's Services or a 20% payment reduction for specified procedures performed in outpatient facilities.

Services Not Covered by the TRI Fee Schedule

TRI Fee Schedule rates do not apply to services billed or rendered by assistant surgeons, Federally Qualified Health Centers, Rural Health Clinics, Indian Health Care Providers, or cost-based reimbursement clinics.

What Providers Should Do

Providers do not need to submit a separate request to receive eligible retrospective payments. Continue submitting claims through the standard process and review remittance information for TRI-related adjustments. Delegated providers should follow the payment and claims-adjustment requirements previously communicated to their organizations.

For additional information and the current TRI Fee Schedule, visit the [DHCS Targeted Provider Rate Increases and Investments webpage](#).

Maternal Mental Health & Depression Screening

San Francisco Health Plan (SFHP) reminds providers to **screen all pregnant and postpartum members for depression**. Additionally, providers must provide and/or refer members to necessary non-specialty mental health services, including individual or group counseling during pregnancy and up to 12 months after pregnancy for members with risk factors.

High-risk members are entitled to preventive counseling and must be referred and coordinated with San Francisco Behavioral Health Services (BHS) when a member may need specialty mental health services.

Additionally, pregnant members in primary care must be provided with basic substance use services and addiction treatment medication if needed.

- For more information on Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT), please click [here](#).
- For information on Medication Assisted Treatment (MAT), please click [here](#).

Non-Specialty Mental Health Services:

To refer a member for non-specialty mental health services, please refer to this [link](#) to access the provider referral forms for Carelon Behavioral Health. You can also call Carelon at **1(855) 371-8117** or visit [carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com).

Specialty Mental Health Services:

To refer a member for specialty mental health services, please contact BHS by calling the 24/7 San Francisco Access Line at **1(415) 255-3737** or visit their [webpage](#) for more information and resources.

Pharmacy - Updated Guidance for the Treatment of Dyslipidemia

DHCS summarized the 2026 Dyslipidemia Guideline, focusing on screening, risk assessment, treatment goals, pharmacotherapy, and side effect monitoring:

1. Lifestyle modifications remain foundational for all patients, including following a heart-healthy diet, reducing saturated and trans fats, engaging in regular physical activity, managing weight, avoiding tobacco, and limiting/eliminating alcohol intake.
2. For primary prevention risk assessment in adults 30-79 years, the 2026 ACC/AHA guideline recommends using the PREVENT-ASCVD outcome-specific equation instead of the Pooled Cohort Equations to estimate 10- and 30-year risk.
3. Statins serve as first-line pharmacotherapy for both primary and secondary prevention.

Prevention Category	Patient Group / Risk Level	LDL-C Goal	Non-HDL-C Goal	Recommendations
Primary	Borderline or Intermediate Risk (3% to <10%)	<100 mg/dL	<130 mg/dL	Consider lipid-lowering therapy based on overall risk assessment
Primary	High Risk (≥10%)	<70 mg/dL	<100 mg/dL	High-intensity statin to achieve ≥50% LDL-C reduction
Primary	Adults 40-75 years with diabetes, CKD stage 3 or 4, or HIV	Follow applicable LDL-C goal based on risk level	Follow applicable non-HDL-C goal based on risk level	Statin therapy recommended regardless of baseline LDL-C

Secondary	Lower-Risk ASCVD	<70 mg/dL	<100 mg/dL	High-intensity statin to achieve ≥50% LDL-C reduction
Secondary	Very High-Risk ASCVD	<55 mg/dL	<85 mg/dL	High-intensity statin to achieve ≥50% LDL-C reduction

- Ezetimibe, bempedoic acid, or PCSK9 inhibitors are recommended when statin and lifestyle changes fail. Advanced risk screening includes measuring Lp(a) at least once in adults, selective testing of apoB, and using coronary artery calcium (CAC) scoring in men ≥40 and women ≥45.

For more information, see the [DHCS article](#).



Facility Site Review Provider Pearls



Vaccine & Immunization Guidance: Preparing for Fall and Beyond

Stay Up to Date: 2026–2027 Season

As we enter the fall and winter respiratory virus season, primary care practices play a critical role in protecting Medi-Cal and Medicare Advantage members from vaccine-preventable illness. California providers should use every preventive, acute, and follow-up visit as an opportunity to assess vaccine status and offer recommended

immunizations.

Priority Vaccines for Fall 2026:

- **Influenza (Flu):** Recommended annually for all individuals 6 months of age and older. Children ages 6 months through 8 years receiving their first influenza vaccine (or who have received only 1 prior dose in total) require two doses administered at least four weeks apart to build an adequate immune response. Early vaccination reduces severe illness, emergency department visits, and hospitalizations during peak months.
- **COVID-19:** Assess vaccination status and offer age-appropriate, updated COVID-19 vaccines following current California Department of Public Health (CDPH) guidance for individuals 6 months and older.
- **Respiratory Syncytial Virus (RSV):** Discuss RSV prevention across all eligible populations:
 - **Maternal Vaccination:** Administered to pregnant individuals at 32–36 weeks gestation using Abrysvo® (RSVpreF).
 - **Infant Immunization:** Direct administration of single-dose monoclonal antibodies—such as Beyfortus® (nirsevimab-alip) or Enflonsia™ (clesrovimab-cfor)—is preferred for most infants, while monthly Synagis® (palivizumab) is reserved for select high-risk cases.
 - **Older Adults:** Screen and offer a single dose of an FDA-approved RSV vaccine—such as Arexvy®, Abrysvo®, or mRESVIA®—to all adults aged 75 and older, as well as adults aged 60–74 who are at increased risk of severe RSV disease.
- **Tdap During Pregnancy:** Administer Tdap during each pregnancy, ideally between 27 and 36 weeks gestation, to protect newborns from pertussis.
- **Adult Preventive Vaccines:** Evaluate eligibility for routine adult immunizations, including zoster (shingles), pneumococcal, and tetanus-containing vaccines, during fall wellness visits to close preventive care gaps before year-end.

Advancing Health Equity in Vaccination

Persistent disparities in adult and pediatric vaccination rates require targeted action. To drive equitable coverage, providers are encouraged to:

- **Communicate Empathetically:** Address vaccine hesitancy using tailored, culturally responsive dialogue.
- **Leverage Proactive Outreach:** Utilize automated reminders, community partnerships, and accessible scheduling tools.
- **Advance Health Equity:** Prioritize engagement across racially, ethnically, and socioeconomically diverse populations facing systemic care gaps.

Documentation & CAIR Compliance Matters

To ensure compliance with Facility Site Review (FSR) standards, HEDIS performance, and state mandates, accurately document vaccine administration:

- Record the vaccine name, manufacturer, lot number, administration date, and Vaccine Information Statement (VIS) edition date in the medical record.
- Document vaccine refusals, including patient counseling provided and the specific rationale.
- **Mandatory Reporting:** Submit all immunization data to the California Immunization Registry (CAIR2) within state-required timeframes.

Provider Reminder: Every patient encounter is an opportunity to vaccinate. Proactive outreach and strong vaccine assessment workflows improve member outcomes and strengthen network quality performance.

Sources: California Department of Public Health (CDPH), West Coast Health Alliance (WCHA), American Academy of Pediatrics (AAP), Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, and American Medical Association (AMA) immunization resources.

“Provider Pearls” are monthly articles written with the intent to help you prepare for the California Department of Health Care Services (DHCS) FSR review processes.

Disclaimer: These suggestions are for educational purposes only. It is not a mandate

and does not replace your organization's clinical policies or contractual obligations. Users are responsible for ensuring their specific processes remain compliant with all applicable state and federal regulations.

Contacts:

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Please do not hesitate to contact Provider Relations at
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