PROVIDER FAQs

FREQUENTLY ASKED QUESTIONS ABOUT THE HEALTH PLAN

GENERAL QUESTIONS

Q: What are the medical coverage options for MPI participants?

A: Participants of the Motion Picture Industry Health Plan ("MPI") may choose from among four medical coverage options for themselves and their dependents.

1. For those enrolled in MPI's health plan for **active participants**, the following medical coverage options are available:
   - Anthem Blue Cross (PPO)
   - Health Net (HMO/Available in California Only)
   - Kaiser Permanente (HMO/Available in California Only)
   - Oxford Health Plans (POS/Available in Connecticut, New Jersey and New York Only)
2. For those enrolled in MPI's health plan for **retired participants**, the following medical coverage options are available:
   - Anthem Blue Cross (PPO)
   - Health Net (HMO/Available in California Only)
   - Kaiser Permanente (HMO/Available in California Only)
   - Oxford Health Plans (POS/Available in Connecticut, New Jersey and New York only)

3. For those enrolled in MPI's health plan for **retired participants** and who are **Medicare-eligible**, the following medical coverage options are available:

   - Anthem Blue Cross/Medicare Advantage (PPO)
   - Health Net (HMO/Available in California Only)
   - Kaiser Permanente Senior Advantage (HMO/Available in California Only)
   - Oxford Health Plans (POS/Available in Connecticut, New Jersey and New York Only)

   The majority of MPI's participants have chosen to enroll in the Anthem Blue Cross/Medicare Advantage (PPO). This is a fully-insured plan that has Affordable Care Act grandfathered status.

Q: What is a benefit?

A: Benefits are services covered by MPI.

Q: Where can I find a comparison of the benefits offered in the health plan?

A: The *Summary Plan Description (SPD)* for both Active and Retired Participants lists and describes all the benefits and benefit exclusions for the Anthem Blue Cross PPO plan. In addition, there is a comparison chart with basic information about the other health plans offered by MPI.

A digital copy of both SPDs can be found on MPI's website. A paper copy can be requested via email at **mpiproviders@mpiphp.org**.

QUESTIONS SPECIFIC TO:

The Motion Picture Industry Health Plan/ Anthem Blue Cross PPO Plan For Active Participants

Q: How are benefit decisions made for the Motion Picture Industry Health Plan/Anthem Blue Cross PPO Plan?

A: MPI staff do not have the authority to make benefit changes. The decisions about coverage and benefits have been made over the years via the bargaining process, and only the Motion Picture Industry Health Plan Board of Directors have the authority to change benefits.

Q: What is the allowed amount?

A: The allowed amount is the contracted rate for Anthem Blue Cross contracted providers and 50% of either the 70th percentile of Usual, Customary and Reasonable (UCR) rates or the Anthem Blue Cross/BlueCard fee schedule less the co-payment per visit (i.e., $30 co-payment if the patient resides in the Motion Picture & Television Fund (MPTF) service area) or $15 co-payment if the patient lives outside the MPTF service area.

The patient is also responsible for any balance billing (i.e., the difference between the billed and allowed amounts).

Q: Who pays the claim, Anthem Blue Cross or MPI?

A: While Anthem writes the check, as a self-funded plan, MPI pays the claim.

Q: What is the Anthem Blue Cross co-payment structure?

The Industry Health Network (TIHN) Providers TIHN, UCLA-MPTF, UCLA/EIMG contracted providers; referrals required	▸ $5.00 co-payment for office visits/treatments. ▸ Covered services are paid at 100% of the contracted rate. ▸ Referrals only apply to professional services and accumulative therapies.
In-Network Providers Anthem Blue Cross contracted providers	▸ $15 or $30 co-payment for office visits/treatments depending on home address on file with MPI (refer to MPTF service area information below). ▸ Covered services are paid at 90% of the contracted rate. ▸ Patient has a 10% co-insurance.
Out-of-Network Providers Non-Anthem Blue Cross providers	▸ $15 or $30 co-payment for office visits/treatments depending on home address on file with MPI (refer to MPTF service area information below). ▸ Covered services are paid at 50% of the allowed amount. ▸ Patient will then be responsible for up to the billed amount.

Q: What is the MPTF service area?

A: The MPTF service area includes the following zip codes:

90004	90026	90057	90290	91208	91350	91390	91506
90005	90027	90064	90401	91214	91351	91401	91522
90006	90028	90066	90402	91301	91352	91403	91601
90007	90029	90067	90403	91302	91354	91405	91602
90009	90034	90068	90404	91303	91355	91406	91604
90010	90035	90069	90405	91304	91356	91411	91605
90016	90016	90077	91201	91306	91364	91423	91606
90018	90036	90295	91202	91307	91367	91436	91607
90019	90038	90210	91203	91311	91377	91501	91608
90020	90046	90211	91204	91316	91381	91502	
90024	90048	90212	91205	91321	91384	91504	
90025	90049	90232	91207	91335	91387	91505	

Q: What is the TIHN network, what is a referral and how do they work?

A: The Industry Health Network (TIHN) consists of the five UCLA-MPTF primary care clinics, and a network of specialists who are contracted with UCLA-MPTF.

Referrals to TIHN specialists can be made by primary care physicians at UCLA-MPTF clinics. With an active referral, the services are paid at 100% of the contracted rate and any applicable co-payments are only $5.

The referrals remain effective for one year, and are valid for providers who are contracted with TIHN only. Referrals do not guarantee a patient's eligibility or coverage of a service. Referrals from TIHN apply to professional charges only, with the exception of accumulated services performed in an outpatient hospital setting (i.e., physical/occupational therapy, speech therapy, nutrition counseling, etc.).

For more information on how to obtain a referral or how to become a TIHN provider, please contact TIHN at (800) 876-8320.

Q: How do I check eligibility for my patients?

A: Please check patient eligibility at **availity.com**.

Q: What is the *Summary Plan Description (SPD)* and why is it so useful?

A: The *SPD* is a manual that includes information about how MPI works. MPI staff and its Board of Directors use the information contained in the *SPD* as the basis for benefit and coverage decisions.

Q: What is MPI's definition of medical necessity?

A: Please see the *SPD* for a definition.

Q: Where can I find the list and description of health benefits and limitations?

A: A list and description of the health plan benefits and limitations can be found in the *SPD*.

Q: Where can I find the list of non-covered services?

A: The list of non-covered services and items can be found in the *SPD*. Also, please refer to MPI's newsletters for any changes after 2013.

Q: Where do I submit a claim?

1. Claims for services rendered in California should be filed with:

   Anthem Blue Cross
   P.O. Box 6007, Los Angeles, CA 90060

2. Claims for services rendered outside of California should be filed with the local Anthem Blue Cross office where the claim was incurred.

Q: How do I file an appeal on a claim?

1. To file an appeal about a claim with MPI:

   If MPI is requesting additional information, or the appeal is for a denial other than "Service not a Plan Benefit," providers may submit medical records/documentation for review. The Claim Review Request form is available on MPI's website at **https://mpiphp.org/src/assets/files/forms/claims/ClaimReviewRequest.pdf**.

   Send a completed Claim Review Request form with any supporting documentation to:

   Motion Picture Industry Health Plan
   Attention: Claims Review Department
   P.O. Box 1999, Studio City, CA 91614
   MPIProviders@mpiphp.org

2. To file an appeal about a claim with Anthem Blue Cross:

   If the provider's local Anthem Blue Cross denies the claim (i.e., claim priced at $0), the provider must appeal to Anthem Blue Cross directly.

   If you are a provider in a state that is part of the Anthem Blue Cross Joint Administrative Agreement group (JAA), please contact Anthem Blue Cross at 800-688-3828 to inquire how to appeal.

   If you are a provider in a state that is BlueCard, please contact your local Blue Cross to inquire how to appeal.

Q: How do I file an appeal on a preauthorization?

1. To file a preauthorization appeal with MPI:

   Preauthorizations may be appealed for denials other than "Service not a Plan Benefit." Any additional medical records or supporting documents that have not already been reviewed should be submitted with the appeal. Please fax additional information and documents to MPI's Medical Review Department at (818) 766-6532 and include the reference number listed at the bottom of your denial letter.

2. To file a preauthorization appeal with Anthem Blue Cross:

   If a preauthorization has been denied by Anthem Blue Cross, the provider must first dispute the denial twice with Anthem Blue Cross. If Anthem Blue Cross denies the second appeal, then the provider can send the preauthorization request to MPI for consideration. The Provider must submit the preauthorization request along with all the appeal denials provided by Anthem Blue Cross.

Q: Is preauthorization required in the Motion Picture Industry Health Plan/Anthem Blue Cross PPO Plan?

A: The Motion Picture Industry Health Plan/Anthem Blue Cross PPO Plan does not require preauthorizations. While a claim will not be denied on the basis that it was not preauthorized, it may not be covered due to other benefit limitations or exclusions or lack of medical necessity. To avoid post-service denials, a preauthorization is strongly recommended for services listed on the Anthem Blue Cross preauthorization list and for any services for which the provider is unsure of coverage.

Please note, MPI is not contracted with American Imaging Management (AIM).

To determine if services meet the criteria for coverage, a preauthorization can be done prior to the services.

Q: Can you please provide me with specific coverage information?

A: The services listed below are a general description of benefits. For complete benefit information, please refer to the *SPD*. For accumulations information, please call MPI at (855) 275-4674.

TIHN Network Providers The Industry Health Network, UCLA-MPTF, UCLA/EIMG contracted providers, referrals required	▸ $5.00 co-payment for office visits/treatments. ▸ Covered services are paid at 100% of the contracted rate. ▸ Referrals only apply to professional services and accumulative therapies.
In-Network Providers Anthem Blue Cross contracted providers	▸ $15 or $30 co-payment for office visits/treatments. ▸ Covered services are paid at 90% of the contracted rate. ▸ Patient has a 10% co-insurance.
Out-of-Network Providers Non-Anthem Blue Cross providers	▸ $15 or $30 co-payment for office visits/ treatments. ▸ Covered services are paid at 50% of the Allowed Amount. ▸ Patient will then be responsible for up to the billed amount.

ACUPUNCTURE

There is a $15 co-payment per visit, with a maximum of 20 acupuncture treatments covered per calendar year (no additional visits will be authorized). To inquire how many visits have been used, please contact (855) 275-4674.

ALLERGY TESTING AND INJECTIONS

Up to 80-unit limit on allergy testing are covered per calendar year. Food allergy testing will be covered for all

patients when medically necessary and when conservative therapies like avoidance of foods that trigger allergies have failed. To be considered for coverage, food allergy testing must be performed or ordered by a physician with special training in the field of allergy and immunology (i.e., ENT, allergist or pulmonary specialist). Direct skin tests are the recommended method of testing. Allergy injections are covered when medically necessary.

AMBULANCE (GROUND & AIR)

For emergency transport, both In-Network and Out-of-Network provider's services will be covered at 90% of the allowed amount. For non-emergency transport/medically necessary services, In-Network Services are covered at 90% of the contracted rate. For non-emergency transport/medically necessary services, services are covered at 50% of the allowed amount. Out-of-Network providers may balance bill the patient.

AMBULATORY SURGICAL CENTER

For an In-Network ambulatory surgical center, the benefit is payable at 90% of the contracted rate. For an Out-of-Network ambulatory surgical center, the benefit is payable at up to $350 max per date of service.

CARDIAC REHABILITATION

Cardiac rehabilitation is covered any time after a cardiac event. A total of 32 cardiac rehabilitation treatments are covered per lifetime regardless of the specific cardiac condition. To inquire how many visits have been used, please contact (855) 275-4674.

CASE MANAGEMENT

Case Management is a voluntary program in which a nurse coordinator works with the patient, the family and the attending physician to develop an individualized and appropriate treatment plan for the purpose of coordination of treatment in the event of a prolonged or catastrophic illness or injury, and to assure that the patient is receiving the most appropriate and cost-effective treatment. To request a Case Management referral, please call MPI at (855) 275-4674.

CHIROPRACTIC

Twenty chiropractic treatments are covered per calendar year regardless of conditions. Additional treatment over the 20 per year will not be authorized. The treatments must be rendered by a licensed chiropractor. Measures which constitute the practice of medicine by a chiropractor are not covered, including the ordering of MRI/CAT scans, diagnostic studies, laboratory tests, prescription drugs, physical therapy and orthotics when ordered by a chiropractor. Other non-covered services include studio calls, on-site calls, home visits, massage therapy and exercise at a gym or similar facility.

For In-Network providers, one office visit, one manipulation and two modalities are covered per date of service. X-rays ordered and/or rendered by the chiropractor are a covered benefit. Benefits are paid at 100% of the contracted rate.

For Out-Of-Network providers, one initial office visit is covered. One manipulation per date of service is covered. X-rays are covered up $159 per year. Benefits are paid up to $54 for the initial visit and $34 for the follow up visits. To inquire how many visits have been used, please call MPI at (855) 275-4674.

COLONOSCOPY

A screening colonoscopy is covered every ten years for most individuals age 50 and over. A diagnostic colonoscopy is covered sooner for some high-risk individuals at an earlier age. A virtual colonoscopy and Cologuard are covered as screening examinations only. Anesthesia is not covered without a preauthorization. To inquire when the patient last used the benefit, please call MPI at (855) 275-4674.

DIABETES EDUCATION

For Type 1 diabetes, MPI will cover counseling sessions with a Certified Diabetes Educator for diabetes

education for Participants and eligible dependents with Type 1 diabetes.

For Type 2 diabetes, Participants and their eligible Dependent(s) who have type 2 diabetes may receive up to three diabetes education sessions per calendar year with a Certified Diabetes Educator or registered dietitian. This benefit is a substitute for the Nutritional Counseling benefit. Benefits are paid at $217.38 max per date of service. To inquire how many visits have been used, please call MPI at (855) 275-4674.

The UCLA course entitled, "Living with Type 2 Diabetes" is a covered benefit for Participants and eligible Dependent(s) with type 2 diabetes. The course is eight hours and requires a physician referral.

PRE-DIABETES

MPI will cover participation in the Diabetes Prevention Program sponsored by Anthem Blue Cross through Solera for pre-diabetics for Participants and their Dependents. The program lasts a year and provides education in diet, exercise and health lifestyle choices designed to prevent the progression of pre-diabetes to diabetes. To qualify for the program and to find out more information, visit **http://www.solera4me.com/mpi** or call (877) 486-0141.

DIABETES SUPPLIES

Most diabetes supplies and insulin are covered and should be obtained through Express Scripts.

Insulin pumps and continuous insulin monitors are covered when Anthem Blue Cross' Medical Policy criteria are met. The policy criteria can be found at **https://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalpolicies/noapplication/f1/s0/t0/pw_034471.htm&na=onlinepolicies&label=Overview**.

EMERGENCY ROOM

In-Network emergency room visits are payable at 90% of the contacted rate, less a $100 co-payment. Out-of-Network emergency room visits are payable at 90% of the allowed amount, less a $100 co-payment. The patient is responsible for any balance billing. The emergency room co-payment is waived if the patient is admitted to the hospital (see Hospital details).

GENETICS

MPI covers genetic tests according to Anthem Blue Cross' policies. Those policies can be found at **https://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalpolicies/noapplication/f1/s0/t0/pw_034471.htm&na=onlinepolicies&label=Overview**.

HEARING AIDS

MPI has contracted with the HearUSA network of audiologists and hearing aid dispensers. Through HearUSA, Participants and their Dependent(s) are eligible for deep discounts on hearing aids resulting in lower out-of-pocket costs. Both HearUSA and Anthem Blue Cross audiologists and hearing aid dispensers are considered In-Network.

HOME HEALTH

For home health, a preauthorization is not required and there is no visit maximum. The treatment must be ordered by a medical doctor and services may be rendered by a LVN, a RN or an MD. Co-payments apply to physician's visits only. Custodial services, nursing assistants, nurse's aides and case workers are not covered. For physical therapy performed in the home, please refer to the physical therapy section.

HOSPITAL ADMITTANCE

For In-Network hospital admittance, the benefit is payable at 90% of the contacted rate, less a $100 co-payment.

For Out-Of-Network hospital admittance, the benefit is payable at 50% of the allowed amount, less a

$100 co-payment. For a preauthorization, please contact Anthem Blue Cross at (800) 274-7767.

MATERNITY BENEFITS

Maternity benefits are the same for single or multiple births. Benefits are payable for normal and Cesarean section delivery, including ante and postpartum care. Maternity benefits are payable only after delivery or termination of pregnancy, including charges for prenatal visits. For full maternity benefits, please refer to the *SPD*.

Effective January 1, 2018, elective abortions are a covered benefit in accordance with the laws of the state in which the procedure is performed.

No maternity or abortion benefits are available for dependent children or surrogates.

Newborns are not automatically added to MPI. For the child to have medical coverage, the child must be added to MPI and will be retroactively enrolled to date of birth.

MOHS SURGERY

MPI uses established guidelines from multiple sources to evaluate the medical necessity of using Mohs surgery to remove skin cancers. The guideline can be found at **https://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalpolicies/noapplication/f1/s0/t0/pw_034471.htm&na=onlinepolicies&label=Overview**.

MONITORED ANESTHESIA CARE (MAC) FOR GASTROINTESTINAL AND PAIN PROCEDURES

MPI covers MAC for gastrointestinal and pain procedures according to Anthem Blue Cross Policy Surg. 00037. This policy can be found at **https://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalpolicies/noapplication/f1/s0/t0/pw_034471.htm&na=onlinepolicies&label=Overview**.

NUTRITION COUNSELING

MPI will cover up to three nutrition counseling sessions per calendar year regardless of the diagnosis. When the counseling is prescribed by a physician and provided by a registered dietitian.
To inquire how many visits have been used, please call MPI at (855) 275-4674.

ORTHOTICS

Orthotics must be ordered by a licensed podiatrist or medical doctor. Orthotics are covered once every two years for people age 17 and older when medically indicated. For people 16 and younger, orthotics are covered once year. To inquire if the patient is currently eligible for the items, please call MPI at (855) 275-4674.

PHYSICAL EXAMS

If a patient is age 18 or older and resides in Los Angeles County, the member must use the UCLA Health-Motion Picture and Television Fund (MPTF) Health Centers for the comprehensive physical exam and related laboratory tests to be covered.

For patients who reside outside of Los Angeles County, there is no UCLA Health Care Center restrictions.

Physical exams are covered once every calendar year and are subject to co-payment and co-insurance. To inquire when the member last used the benefit, please contact (855) 275-4674. Physical exams and medical/sick office visits are not covered when rendered during the same visit.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AQUATIC THERAPY

A maximum of 16 combined physical/occupational/aquatic therapy treatments are covered per calendar year. Treatment must be prescribed by a medical doctor; self-referrals to a physical or occupational therapist will not be a covered benefit. Preauthorization is not required for the initial 16 visits of the calendar year. The treatment must be prescribed by a medical doctor and must be rendered by a registered physical therapist, an occupational therapist, a doctor of osteopathy or a medical doctor. Initial visit/evaluation is allowed separately.

Additional treatment will be reviewed for possible coverage based on medical information provided by the treating physician. Preauthorization is recommended. If a patient uses all of the 16 covered visits for one injury or surgery and sustains an entirely different injury or surgery later in the calendar year, an additional 16 visits for the second incident may be approved upon request and review by MPI's Medical Review Department.

To request preauthorization for additional treatment, please complete the Preauthorization form available at **https://mpiphp.org/src/assets/files/forms/medical_review/MedicalPre-authForm.pdf**.

At least 12 visits must be exhausted and applied to the MPI claims accumulator. Please fax the Preauthorization form to MPI's Medical Review Department at (818) 766-6532 along with the new prescription for the additional treatment, progress notes from the treating physician's office and all physical therapy/ occupational therapy/aquatic therapy treatment notes. Review may take 7-14 business days. To inquire how many visits have been used, please call MPI at (855)275-4674.

SKILLED NURSING

Participants are covered for 90 days and eligible dependents are covered for 60 days in a skilled nursing facility. For In-Network facilities, the patient will have a 10% co-insurance. For Out-of-Network facilities, the patient will be responsible for the remainder up to the billed amount. To inquire how many visits have been used, please call MPI at (855) 275-4674. Custodial services are not covered. When MPI is the primary insurance carrier preauthorization is required from Anthem Blue Cross by calling (800) 274-7767.

SLEEP APNEA

For a sleep study to be covered, the study must be ordered by a medical doctor. Preauthorization by MPI's Medical Review Department is recommended. Fax a preauthorization request, along with a completed sleep study questionnaire and office and/or consultation notes, to (818) 766-6532.

The Preauthorization form and the sleep study questionnaire can be found at **https://mpiphp.org/src/assets/files/forms/medical_review/PhysSlpStdyQues.pdf** and **https://mpiphp.org/src/assets/files/forms/medical_review/MedicalPre-authForm.pdf**.

Standard CPAP Supply Frequency Allowances are as follows:

- Tubing w/heating element - 1 per 3 months
- Full Face Mask - 1 per 3 months
- Full Face Mask Cushion - 1 per month
- Nasal Mask Cushion - 2 per month
- Nasal Pillows (pair) - 2 per month
- Nasal Mask - 1 per 3 months
- Headgear - 1 per 6 months
- Chinstrap - 1 per 6 months
- Tubing - 1 per 3 months
- Filter, disposable - 2 per month
- Filter, non-disposable - 1 per 6 months
- Replacement Water Chamber - 1 per 6 months

For a CPAP, BiPAP or APAP, a preauthorization from MPI's Medical Review Department is recommended. Fax a preauthorization request, along with the sleep study, to (818) 766-6532. Three-month trial compliance data is required for future coverage. CPAPs are covered for rent to own only, up to a total of 10 months.

SPEECH THERAPY

A maximum of 32 speech therapy treatments are covered per calendar year. Preauthorization by MPI's Medical Review Department is recommended. Fax a speech therapy questionnaire, completed by a licensed speech pathologist with relevant medical documentation, to (818) 766-6532.

The Preauthorization form and speech therapy questionnaire is available at **https://mpiphp.org/src/assets/files/forms/medical_review/MedicalPre-authForm.pdf** and **https://mpiphp.org/src/assets/files/forms/medical_review/SpeechTherapy.pdf**.

For full benefit and coverage information, please refer to the *SPD*.

TRANSPLANTS

Transplants must be preauthorized by Anthem Blue Cross by calling (800) 274-7767. The donor search is not a covered benefit. Once the donor is selected, MPI will cover related expenses.

WELL-WOMAN EXAMS

Well-woman exams are covered once every calendar year and are subject to a co-payment and co-insurance. To inquire when the patient last used the benefit, please call MPI at (855) 275-4674.

Physical exams and medical/sick office visits are not covered when rendered during the same visit.

Q: What is the Benefits/Appeals Committee?

A: The Benefits/Appeals Committee has the discretion and final authority to interpret and apply the plan of benefits, the Trust Agreement and any and all rules governing MPI. A formal review by the Benefits/Appeals Committee of an adverse benefit determination may be requested by the provider or a patient. The request must be in writing and submitted within 180 days following the receipt of the explanation of benefits or other notification of denial. The decisions of the Benefits/Appeals Committee are final and binding on all parties. Requests for review must be addressed to:

Motion Picture Industry Health Plan
Attention: Benefits/Appeals Committee
P.O. Box 1999, Studio City, CA 91614-0999