2025 Medi-Cal Operations Guide

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INTRODUCTION

The Health Net* *Medi-Cal Operations Guide* is a summary of Health Net's Medi-Cal county-specific provider manuals that are available in Health Net's Medi-Cal Provider Library on the Health Net provider website. Providers are encouraged to use the electronic version of the applicable county-specific manual when possible for the most current information. Updated information in the electronic version of the manual supersedes information contained in this print guide.

The contents of this guide are supplemental to the *Provider Participation Agreement (PPA)*. When the contents of this guide conflict with the *PPA*, the *PPA* takes precedence. Updates to the information in this guide are made through provider updates or signed letters distributed by fax, the United States Postal Service or other carrier. Provider updates and signed letters are to be considered amendments to this guide.

How to Use the Guide

This guide contains the essential components of Health Net's Medi-Cal plan. Refer to it for basic information about public health programs available to Medi-Cal patients, use of and access to Medi-Cal services, physician responsibilities for coordination of patient care, and provision of health care services.

The primary focus of the guide is in Chapters 4 through 7, which provide explanations of pertinent public health programs, medical service standards and sensitive services and self-referral program considerations.

Chapter 1 contains contact information for plan and public health agencies. Chapter 2 describes enrollment criteria and procedures unique to the Medi-Cal managed care program. Chapter 3 describes access to care standards and referral and prior authorization requirements. Chapter 8 includes information on continuity of care, utilization management and health education programs available to Medi-Cal members. Chapters 9 and 10 provide general information about claims, encounters, appeals, and grievances.

Contractual Arrangements and Applicability to Los Angeles County

As a general rule, providers participating through a subcontracting health plan, such as Molina Healthcare, follow the subcontracting plan's operational procedures; however, standard Medi-Cal policies for public health program interaction as described in this guide apply to all participating providers, including providers contracting through Molina. Los Angeles County is a Two-Plan Model Program area. Under the Two-Plan Model Program, the Department of Health Care Services (DHCS) contracts with one commercial plan, the Commercial Plan, and one Medi-Cal plan developed by the county, the Local Initiative.

In Los Angeles County, DHCS awarded Health Net the Commercial Plan contract. Health Net entered into contract with Molina in Los Angeles County as a subcontracting plan to provide Medi-Cal services through its respective provider network. Medi-Cal members in Los Angeles County are Health Net members, even if assigned to Molina.

Disclaimer

This guide is not intended to provide legal advice on any matter and may not be relied on as a substitute for obtaining advice from a legal professional.

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a Department of Health Care Services (DHCS) initiative to address the social determinants of health and improve health equity statewide. To support the CalAIM initiative, services listed below are available to eligible Medi-Cal members. Health Net contracts with community-based ECM providers who have experience serving the ECM populations of focus (see table on page 3), and expertise providing the core ECM services, to provide services to eligible members under the Medi-Cal ECM benefit.

- **Enhanced Care Management (ECM)** – ECM offers extra services at no cost to members who have complex needs that make it hard to improve their health. This includes access to a single Lead Care Manager who provides comprehensive care management and coordinates their health and health-related care and services.
- **Community Supports (CS) services** – There are 14 DHCS-approved CS services to address the needs of members – including those with the most complex challenges affecting health, such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs. Refer to the table on page 4 for detailed descriptions of the 14 CS services.
- **Doula services** – Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas are not licensed, and they do not require supervision. Doulas do not diagnose medical conditions, provide medical advice, or clinical assessment, exam, or procedure. You can help connect members to local doulas listed in the provider directory or by calling member services for a list of local doulas.
- **Community Health Worker (CHW) services** – CHW services are considered preventive care services that provide health education and navigation services to help members get the care they need. Community Health Workers are members of the community, such as community health representatives and non-licensed public health workers, including violence prevention professionals. You can connect members to local CHW organizations listed in the provider directory or by calling provider services for assistance.
- **Street Medicine** – The street medicine benefit covers up to the full array of services necessary to meet immediate needs of Medi-Cal members experiencing unsheltered homelessness. Services include but are not limited to, preventive services, and the treatment of acute and chronic conditions.

Refer to the table below for some examples of the various resources to support your Medi-Cal patients. These are available on the **CalAIM Resources for Providers** page at **www.healthnet.com/providers/CalAIM**.

Resources	Description
End-to-End Workflows	Refer to the end-to-end referral process for Community Supports (CS), Enhanced Care Management (ECM), doula, Community Health Worker and street medicine services.
Forms and tools	Forms and tools are available to providers to: • Use the Community Supports authorization guides to help determine member qualification for CS services. Learn more on how to refer members to CS services with the Community Supports Quick Reference Guide (PDF). • Use the ECM referral form to screen for member eligibility and refer members to ECM services • Use the Findhelp How-to-Guide to identify local resources and refer members through the findhelp online platform. • Search the provider directories to find doctors, hospitals ECM organizations, CS organizations, doulas, CHWs, and other providers.
Data Collection	Providers who are interested in becoming an ECM or CS provider can complete the interest form and certification application.
Communications	Access archived CalAIM-specific provider notifications to help you stay informed on the latest news.

ECM Populations of Focus

The ECM populations of focus eligible for the ECM benefit are:

ECM Populations of Focus	Adults ages 21 and over	Children & youth up to age 21
1. Individuals experiencing homelessness: a. Adults without Dependent Children/Youth Living with Them Experiencing Homelessness b. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	X	
2. Individuals at risk for avoidable hospital or emergency department (ED) utilization (formerly called high utilizers)	X	X
3. Individuals with serious mental health and/or substance use disorder (SUD) needs	X	X
4. Individuals transitioning from incarceration	X	X
5. Adults living in the community and at risk for long-term care institutionalization	X	
6. Adult nursing facility residents transitioning to the community	X	
7. Children or youth enrolled in California Children's Services (CCS) or CCS whole child model (WCM) with additional needs beyond the CCS condition		X
8. Children or youth involved in child welfare		X
9. Birth Equity	X	X

CS Services

CS Services	Description
Housing Transition Navigation Services	Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.
Housing Deposits	Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically-necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.
Housing Tenancy and Sustaining Services	Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.
Short-Term Post-Hospitalization Housing	Members who do not have a residence, and who have high medical or mental health and substance use disorder needs, receive short-term housing for up to six months to continue their recovery. To receive this support, members must also have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.
Recuperative Care (Medical Respite)	Members with unstable housing who no longer require hospitalization, but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.
Respite Services	Short-term relief for caregivers of members. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.
Day Habilitation Programs	Members who are experiencing homelessness, are at risk of experiencing homelessness, or formerly experienced homelessness, receive mentoring by a trained caregiver on the self-help, social, and adaptive skills needed to live successfully in the community. These skills include the use of public transportation, cooking, cleaning, managing personal finances, dealing with and responding appropriately to governmental agencies and personnel, and developing and maintaining interpersonal relationships. This support can be provided in a member's home or in an out-of-home, nonfacility setting.
Nursing Facility Transition/ Diversion to Assisted Living Facilities	Members living at home or in a nursing facility are transferred to an assisted living facility to live in their community and avoid institutionalization in a nursing facility, when possible. Assisted living facilities provide services to establish a community facility residence such as support with daily living activities, medication oversight, and 24-hour onsite direct care staff.
Community Transition Services/ Nursing Facility Transition to a Home	Members transitioning from a nursing facility to a private residence where they will be responsible for their own expenses, receive funding for set-up services such as security deposits, set-up fees for utilities, and health-related appliances, such as air conditioners, heaters, or hospital beds.
Personal Care and Homemaker Services	Members who require assistance with Activities of Daily Living or Instrumental Activities of Daily Living receive in-home support such as bathing or feeding, meal preparation, grocery shopping, and accompaniment to medical appointments.
Environmental Accessibility Adaptations (Home Modifications)	Members receive physical modifications to their home to ensure their health and safety, and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.
Medically Supportive Food/ Medically Tailored Meals	Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.
Sobering Centers	Members who are found to be publicly intoxicated are provided with a short-term, safe, supportive environment in which to become sober. Sobering centers provide services such as medical triage, a temporary bed, meals, substance use education and counseling, and linkage to other health care services.
Asthma Remediation	Members receive physical modifications to their home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.

CHAPTER 1 – WHO TO CONTACT

Resources for providers and members are described below, followed by a listing of phone numbers and addresses for contacting Health Net departments or public health programs providing Medi-Cal services. Providers should refer to both the statewide and the county-specific directories for applicable contacts.

For Los Angeles County, resources and contacts are provided specific to Health Net and the subcontracting plan, Molina Healthcare. Providers contracting through Molina must use the contacts affiliated with their plan.

Provider Resources

PROVIDER NETWORK MANAGEMENT

Regional provider network managers and network administrators are key contacts for participating physician groups (PPGs), hospitals and other providers. They resolve contractual and operational matters and conduct training sessions to keep participating providers abreast of policy, operational and product changes.

REGIONAL MEDICAL DIRECTORS

Regional medical directors assist PPGs, hospitals and other providers in resolving clinical matters related to Health Net's policies and procedures. To provide better service to PPGs, hospitals and members, Health Net's regional medical directors are located in Medi-Cal designated regional offices. Health Net's regional medical directors are directly responsible for any clinical matters related to Health Net policies and procedures. They also serve as professional consultants to the PPGs and hospitals.

PUBLIC PROGRAMS DEPARTMENT

The Health Net Public Programs Department ensures that Medi-Cal members have access to public health programs. The department's primary responsibility is to coordinate care with various public health entities and programs.

The Health Net Public Programs Department is staffed with public programs specialists in Health Net's Medi-Cal counties. Health Net's public programs administrators work to find strategies to improve health care delivery.

The Public Programs team helps with resolving access to care issues, care coordination issues and work with managed long-term services and support programs and can be reached at Help_Referral@Healthnet.com or 800-526-1898.

PROVIDER RELATIONS DEPARTMENT

The Health Net Medi-Cal Provider Relations Department primarily provides support, education and training to Health Net's Medi-Cal provider network.

COMPLIANCE DEPARTMENT

The Facility Site Review (FSR) Compliance Department develops materials that educate providers on legal and accrediting requirements, medical record criteria, documentation of preventive care services, health education, continuity of care and other clinical interventions, public health programs, and disease management.

PROVIDER SERVICES DEPARTMENT

Medi-Cal Provider Services Department representatives are available Monday through Friday, 8 a.m. to 6 p.m. Pacific time (PT) to assist providers with member eligibility, primary care physician (PCP) selection and transfer requests for members, benefit information, claims, billing, complaints and grievances, and other provider inquiries.

INTERPRETER SERVICES

Interpreter services are offered to participating providers and members at no cost to ensure they have access to qualified interpreters trained in health care terminology, interpreting protocols and ethics, and to support common communication challenges across cultures. Member and providers may request an interpreter by calling 800-675-6110 (TTY:711).

Similar interpreter services are available to Molina members and participating providers by calling 888-665-4621 to speak with a Molina representative. Molina uses an outside interpretation service if staff is unavailable to provide service to the member.

Member Resources

HEALTH EDUCATION

The Health Education System promotes resources and programs to educate members about how to improve their health, the importance of preventive screenings, recognizing potential health risks, and minimizing existing health problems. The department offers health education brochures, newsletters, virtual classes and other information in various threshold languages at no cost through self-referral or a referral from their PCP.

HEALTH EQUITY DEPARTMENT

The Health Equity Department aims to help all the people and communities we serve achieve the highest level of health by advancing equity in health and health care. The Health Equity strategy includes cross-functional collaboration, to ensure all teams are aligned on the Health Equity goals, ensure coordination of strategies across lines of business and departments, and utilize governance structures focused on advancing health equity, addressing social needs, and mitigating social risks. The Health Equity Department provides oversight, implementation, and operational support to the Health Equity strategy. The Health Equity Department adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards represent 15 different standards that serve as the foundation for the development of the Health Equity Department strategic plans. CLAS standards are “intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services.”

MEDI-CAL MEMBER SERVICES DEPARTMENT

The Medi-Cal Member Services Department handles for phone calls and correspondence from members regarding problems and inquiries; Medi-Cal questions and information; professional and hospital services, bills and claims; address changes; PCP selection and changes; identification (ID) card requests; and member grievances.

Phone Numbers and Addresses

Statewide Phone Numbers

COMMUNICATIONS

The Health Net Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, and changes in contractual, legislative and regulatory requirements through provider operations manuals, updates and letters.

provider.communications@healthnet.com

CULTURAL AND LINGUISTIC SERVICES

The Health Equity Department promotes access to care for members who speak a primary language other than English and can help facilitate interpretation services.

cultural.and.linguistic.services@healthnet.com
800-977-6750
Fax: 818-543-9188

DELEGATION OVERSIGHT

The Health Net Delegation Oversight Department oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies.

Fax: 866-476-0311

DENTI-CAL

Denti-Cal covers annual dental screenings for Medi-Cal members as described in periodic health exam schedules, emergency dental care and other dental services not covered under Health Net's Medi-Cal contracts.

800-322-6384

DHCS MANAGED CARE OMBUDSMAN

The Department of Health Care Services (DHCS) managed care ombudsman investigates and attempts to resolve complaints about managed care plans that members have been unable to resolve through their health plans.

888-452-8609

DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

The Department of Managed Health Care (DMHC) regulates managed care plans in California. DMHC may assist members with complaints involving emergency grievances or grievances that have not been satisfactorily resolved by the health plan.

888-466-2219

DEPARTMENT OF SOCIAL SERVICES (DSS)

The DSS Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding fair hearings and grievances.

PO Box 944243, M.S. 19-17-37, Sacramento, CA 94244-2430
800-952-5253
Fax: 916-229-4110

ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse. All other questions regarding electronic claims submission should be directed to Health Net's EDI Department.

800-977-3568
Email: edi.support@healthnet.com

ELIGIBILITY VERIFICATION

Health Net's Medi-Cal Provider Services Department verifies member eligibility. Eligibility can also be verified online 24 hours a day, seven days a week, 365 days a year through Health Net's website at www.healthnet.com.

800-675-6110

ENCOUNTERS

Contact the Health Net Encounter Department via email with encounter data questions.

Enc_Group@healthnet.com

FRAUD HOTLINE

Suspected cases of health care fraud and abuse by providers or members should be reported to Centene's Compliance and Ethics help line.

800-977-3565

HEALTH CARE OPTIONS (HCO)

The HCO contractor processes Medi-Cal managed care enrollments and disenrollments. Refer members to the appropriate toll-free numbers listed below:

Arabic
800-576-6881

Armenian
800-840-5032

Cambodian
800-430-5005

Cantonese
800-430-6006

English and other languages
800-430-4263

Farsi
800-840-5034

Hmong
800-430-2022

Korean
800-576-6883

Laotian

800-430-4091

Mandarin
800-576-6885

Russian
800-430-7007

Spanish
800-430-3003

Tagalog
800-576-6890

Vietnamese
800-430-8008

TTY/TDD (hearing impaired)
800-430-7077

HEALTH CARE SERVICES

The Health Care Services Department conducts concurrent review of inpatient cases and coordinates coverage for patients under the care management program. Contact Prior Authorization by phone or fax to request elective and urgent services.

Prior Authorization
800-421-8578
Fax: 800-743-1655

PHARMACY SERVICES

Pharmacy services is responsible for review of prior authorization requests for medication covered under the medical benefit for Health Net Medi-Cal members.

MedPharm
Attention: Prior Authorization
4191 East Commerce Way, Sacramento, CA 95834
Mailstop: CA4151-04-530
800-867-6564
Fax: 833-953-3436

HEALTH NET WEBSITE

Health Net's website offers information about member eligibility, claim status, Health Net reference materials such as *Evidence of Coverage*, county-specific Medi-Cal operations manuals, forms, and information about how to contact Health Net with questions.

provider.healthnet.com

HOSPITAL NOTIFICATION UNIT

Hospitals are required to contact the Health Net Hospital Notification Unit within 24 hours of an admission or one business day when an admission occurs on the weekend or holiday for any Health Net member. Failure to notify according to the requirements in the *Provider Participation Agreement (PPA)* may result in a denial of payment.

800-995-7890
Fax: 800-676-7969

INTERPRETER SERVICES

Interpreter services are offered to participating providers at no cost to ensure effective communication with members.

800-675-6110 (TTY:711)

MEDI-CAL CLAIMS

Send written correspondence, claims, tracers, adjustment requests, or denial reconsiderations to Health Net Medi-Cal Claims at the following address:

PO Box 9020, Farmington, MO 63640-9020

MEDI-CAL MEMBER SERVICES

The Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage
- Information about access to and delivery of care
- Professional and hospital services, bills, and claims
- Member problems and inquiries
- Address changes
- Identification card requests
- Primary care physician (PCP) selection and transfer requests
- Handling complaints about Health Net programs or staff

800-675-6110, open 24/7
Fax: 844-837-5947 or 800-281-2999

MEDI-CAL MEMBER APPEALS AND GRIEVANCES DEPARTMENT

- By phone: Contact Health Net 24 hours a day, 7 days a week by calling 800-675-6110 (TTY: 711).
- In writing: Fill out an appeal form or write a letter and send it to:
  Health Net Medi-Cal Member Appeals and Grievances Department
  P.O. Box 10348, Van Nuys, CA 91410-0348
  Fax: 1-877-713-6189

  The doctor's office will have appeal forms available. Health Net can also send a form to the member.
- Electronically: Visit the health plan website at www.healthnet.com.

MEDI-CAL PROVIDER APPEALS UNIT

Submit claims appeals to Health Net Medi-Cal Provider Appeals Unit at the following address:

PO Box 989881, West Sacramento, CA 95798-9881

MEDI-CAL PROVIDER SERVICES DEPARTMENT

The Provider Services Department assists providers with:

- Member eligibility, effective dates, and eligibility research
- PCP selection and transfer requests for members
- Questions about the Plan's Medi-Cal Rx Contract Drug List (CDL)
- Benefit information
- Claims and professional and hospital billing
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/PCP/PPG reassignment for non-compliant members

800-675-6110, option 2
Fax: 844-837-5947 or 800-281-2999

Only if the provider portal is down or not working, providers may use the below email for claim status and denial inquiries.

Email: hnmedi-cal.claimsinquiry@healthnet.com

BEHAVIORAL HEALTH PROVIDER SERVICES

If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or their staff may contact Health Net for a referral to a behavioral health provider.

844-966-0298

NURSE ADVICE LINE

The nurse advice line is staffed 24 hours a day, seven days a week by registered nurses for member assistance.

800-675-6110

STATE HEALTH PROGRAMS QUALITY IMPROVEMENT DEPARTMENT

Contact the State Health Programs Quality Improvement Department for information about quality improvement projects for Health Net's Medi-Cal members.

Cqi_dsm@healthnet.com

Amador County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

Public programs administrators interact with public health departments and programs and work with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

CALIFORNIA CHILDREN'S SERVICES (CCS)

County Department of Health
10877 Conductor Blvd., Ste. 400, Sutter Creek, CA 95685
209-223-6630
Fax: 209-223-3524

COMMUNICABLE DISEASE

County Department of Health,
Communicable Disease Control
10877 Conductor Blvd, Sutter Creek, CA 95685
209-223-6407
Fax: 209-223-1562

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Amador County Public Health (03)
10877 Conductor Blvd. 400, Sutter Creek, CA 95642
209-223-6407
Fax: 209-223-3524

COUNTY MENTAL HEALTH PLAN

Facility name

10877 Conductor Blvd. Suite #300, Sutter Creek, CA 95685
888-310-6555
209-223-6412
Fax: 209-223-0920

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

Area 12 Agency on Aging

19074 Standard Road, Sonora, CA 95370
209-532-6272
Fax: 209-532-6501

REGIONAL CENTERS

Valley Mountain Regional Center

702 North Aurora Street Stockton, CA 95202
209-473-0951
Fax: 209-473-0256

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

430 Sutter Hill Rd., Sutter Creek, CA 95685
209-223-7685

Calaveras County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

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21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
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800-675-6110
Fax: 800-628-2704

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800-526-1898
Fax: 866-922-0783

Public Health Agencies

CALIFORNIA CHILDREN'S SERVICES (CCS)

County Department of Health
Mail: 891 Mountain Ranch Road, San Andreas, CA 95249-9713
700 Mountain Ranch Road, Suite C2, San Andreas, CA 95249
209-754-6460
Fax: 209-754-1710

COMMUNICABLE DISEASE INVESTIGATION PROGRAM

County Department of Health, Communicable Disease Control
700 Mountain Ranch Road, Suite C-2, San Andreas, CA 95249
209-754-6460
Fax: 209-754-1709

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Calaveras Public Health Department (05)
891 Mountain Ranch Road, San Andreas, CA 95249
209-754-6464
Fax: 209-754-6459

COUNTY MENTAL HEALTH PLAN

Calaveras County Behavioral Health

891 Mountain Ranch Road, San Andreas, CA 95249
800-499-3030
209-754-6525
Fax: 209)-754-6534

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

Area 12 Agency on Aging

19074 Standard Road, Sonora, CA 95370
209-532-6272
Fax: 209-532-6501

REGIONAL CENTERS

Valley Mountain Regional Center

702 North Aurora Street Stockton, CA 95202
209-473-0951
Fax: 209-473-0256

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

209-223-7685

Inyo County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

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21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

Public programs administrators interact with public health departments and programs and work with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

CALIFORNIA CHILDREN'S SERVICES (CCS)

County Department of Health
1360 N. Main Street, Suite 203-C, Bishop, CA 93514
760-873-7868
Fax: 760-873-7800

COMMUNICABLE DISEASE INVESTIGATION PROGRAM

County Department of Health,
Communicable Disease Control
1360 N. Main Street, Bishop, California 93514
760-873-7868
Fax: 760-873-7800

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Inyo County Health Department (14)
Marissa Whitney, PSC
207 A West South Street, Bishop, CA 93514
760-873-7868
Fax: 760-873-7800

COUNTY MENTAL HEALTH PLAN

Behavioral Health Services

1360 North Main Street, Suite 124, Bishop, CA 93514
800-841-5011
Fax: 760-873-3277

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

Eastern Sierra Area Agency on Aging

1360 North Main Street, Suite 201, Bishop, CA 93514-2709
760-873-3305
Fax: 760-878-0266

REGIONAL CENTERS

Kern Regional Center

3200 North Sillect Avenue Bakersfield, CA 93308
661-327-8531
Fax: 661-324-5060

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

760-872-1885

Los Angeles County

Public Health Agencies

AltaMed Health Services Corp, HIV Services Division
5427 East Whittier Blvd., Los Angeles, CA 90022-4101
877-462-2582

Minority AIDS Project
5149 W. Jefferson Blvd., Los Angeles, CA 90016
323-936-4949

Tarzana Treatment Center
18646 Oxnard St., Tarzana, CA 91356-1486
818-342-5897
Fax: 818-345-6256

St. Mary Medical Center Care Program
1045 Atlantic Ave., Ste. 1016, Long Beach, CA 90813
562-624-4900

CALIFORNIA CHILDREN'S SERVICES (CCS)
County Department of Health
9320 Telstar Ave., Ste. 226, El Monte, CA 91731
800-288-4584
Fax: 855-481-6821

COMMUNITY-BASED ADULT SERVICES CENTERS
A Plus Adult Day Health Care
3321 Tyler Ave., El Monte, CA 91731
626- 579-6588
Fax: 626-579-6586

Antelope Valley Adult Day Health Care Center
44902 10th St. W, Ste. 8, Lancaster, CA 93534
661-949-6278
Fax: 661-949-6768

Ararat Adult Day Health Care Center
721 South Glendale Ave., Glendale, CA 91205
818-240-1721
Fax: 818-240-2160

Arcadia Adult Day Health Care Center
15 Las Tunas Dr., Arcadia, CA 91007
626-447-9700
Fax: 626-446-5405

Arcadia of Hollywood Adult Day Health Care Center
860 North Highland Ave., Los Angeles, CA 90038
323-466-4122
Fax: 323-466-4144

Babylon Adult Day Health Care Center
18725 Sherman Way, Reseda, CA 91335
818-996-9300
Fax: 818-996-8600

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)
Los Angeles
213-639-6419

LOCAL HEALTH DEPARTMENT/DISEASE REPORTING
313 North Figueroa St., Room 117, Los Angeles, CA 90012
888-397-3993
Fax: 213-482-5508

MENTAL HEALTH PLAN
County Mental Health Plan
550 South Vermont Ave., Los Angeles, CA 90020
800-854-7771

REGIONAL CENTERS
Eastern Los Angeles Regional Center
1000 South Fremont Ave., PO Box 7916, Alhambra, CA 91802-4700
626-299-4700

Frank D. Lanterman Regional Center
3303 Wilshire Blvd., Ste. 700, Los Angeles, CA 90010-2197
213-383-1300

Harbor Regional Center
21231 Hawthorne Blvd., Torrance, CA 90503
310-540-1711

North Los Angeles Regional Center
9200 Oakdale Ave., Ste. 100, Chatsworth, CA 91311
818-778-1900

San Gabriel/Pomona Regional Center
75 Rancho Camino Dr., Pomona, CA 91766
909-620-7722

South Central Los Angeles Regional Center

2500 S. Western Ave., Los Angeles, CA 90018
213-744-7000

Westside Regional Center
5901 Green Valley Circle, Ste. 320, Culver City, CA 90230-1024
310-258-4000

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)
Antelope Valley Hospital
661-949-5805

Harbor-UCLA Research and Education Institute
310-661-3080

Long Beach
562-570-4242

Northeast Valley Health
818-361-7541

Orange County Health Care
888-968-7942

Pasadena
626-744-6520

Public Health Foundation
888-942-2229
626-856-6600

Los Angeles County – Health Net

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

The Public Programs Department interacts with public health departments and programs and works with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Los Angeles County – Molina Healthcare

COMMUNITY ENGAGEMENT DEPARTMENT

The Molina Community Engagement staff provides outreach and organizes participation in community events, such as health fairs.

855-MOLINA (855-665-4621)

CORPORATE OFFICES

200 Oceangate, Ste. 100, Long Beach, CA 90802
562-435-3666
800-526-8196

CREDENTIALING AND FACILITY SITE REVIEW

The Molina Medical Staff Services/Credentialing Department verifies all information for Credentialing Committee approval on each Molina provider in order to evaluate the applicant's qualifications to be credentialed or recredentialed.

Credentialing
888-562-5442, ext. 120117
Fax: 888-665-4629

Facility Site Review
888-562-5442, ext. 120118
Fax: 562-499-6185

ENCOUNTER DEPARTMENT

The Molina Encounter Department handles all claims for capitated services.

MHCEncounterDepartment@MolinaHealthCare.com

HEALTH EDUCATION DEPARTMENT

The Molina Health Education Department improves the health of Medi-Cal members through member and provider education and by facilitating provider access to patient education resources and information.

866-472-9483

INTERACTIVE VOICE RESPONSE

Contact the Molina interactive voice response (IVR) system if a patient arrives at a PCP office to receive care and does not appear on the current month's eligibility listing.

800-357-0172, press 2

INTERPRETER SERVICES

Telephonic interpreter services are available through the Molina Member Services Department.

888-665-4621

MEDI-CAL CLAIMS

Claims submissions, and corrected or consented claims:

Molina Healthcare of California
PO Box 22702, Long Beach, CA 90801

Provider appeals and disputes
Molina Healthcare of California
PO Box 22722, Long Beach, CA 90801
Attn: Provider Dispute Resolution Unit

To check a status for a claim, contact the Claims Contact Center at 888-665-4621, Monday through Friday, 8 a.m. to 5 p.m.

MOLINA HEALTHCARE'S WEBSITE

Molina Healthcare's website hosts information about prior authorization criteria, provider training, resource documents, manuals, frequently used forms, plan policies, and phone numbers.

www.molinahealthcare.com

NURSE ADVICE LINE

Molina's nurse advice line is staffed 24 hours a day, 7 days a week, by highly trained nurses for member assistance.

English
888-275-8750

Spanish
866-648-3537

PHARMACY AUTHORIZATION

The Molina Pharmacy Authorization Desk is responsible for Molina's medication prior authorization requests.

888-665-4621
Fax: 866-508-6445

PROVIDER RESOLUTION DEPARTMENT

Molina Healthcare's Provider Dispute Resolution Department handles written inquiries from providers regarding claim disputes. Written inquiries should be sent to the following address or fax line:

Molina Healthcare
Attn: Provider Dispute Unit
PO Box 22722, Long Beach, CA 90801
Fax: 562-499-0633

Phone inquiries should be directed to the Molina Customer Service

Department. 888-665-4621

PROVIDER SERVICES DEPARTMENT

The Molina Healthcare Provider Services Department is the provider liaison to the health plan's administrative programs. This department handles phone and written inquiries from providers regarding contracting, capitation verification, scheduling of in-service training, site audit status, and credentialing information.

200 Oceangate, Ste. 100, Long Beach, CA 90802
855-322-4075
Fax: 855-278-0312

QUALITY IMPROVEMENT

The Molina Quality Improvement Department reviews member medical records, population-based studies on preventive care, clinical practice guidelines, focused studies, member and provider satisfaction studies, complaints and grievances, and monitoring continuing quality improvement.

800-526-8196, ext. 126137
Fax: 562-499-6185

UTILIZATION MANAGEMENT, CCS AND CASE MANAGEMENT

The Molina Utilization Management (UM) Department reviews prior authorization requests, conducts concurrent review on inpatient cases and coordinates care for patients. UM concurrent review clinicians (CRCs) actively partner together to coordinate discharge planning and referrals to Case Management. Pediatrics eligible for California Children's Services (CCS) or a Regional Center (RC) may be discussed with the dedicated CCS/RC team. The Molina UM Department dedicated toll-free phone number listed below is staffed 24 hours a day, seven days a week.

Utilization Management (all inquiries)
844-557-8434

Outpatient and prior authorization requests
Fax: 800-811-4804

Notification of inpatient admissions and submission of clinical documentation
Fax: 866-553-9262

Case management referral
800-526-8196, ext. 127604
Fax: 562-499-6105

BEHAVIORAL HEALTH SERVICES

Behavioral Health Services assists providers with mental health services for Molina

members. 888-665-4621

Mono County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

Public programs administrators interact with public health departments and programs and work with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

CALIFORNIA CHILDREN'S SERVICES (CCS)

County Department of Health
Mail: P.O. Box 3329, Mammoth Lakes, CA 93546
1290 Tavern Road, Suite 246, Mammoth Lakes, CA 93546
760-924-1848
Fax: 760-924-1831

COMMUNICABLE DISEASE INVESTIGATION PROGRAM

County Department of Health,
Communicable Disease Control
1290 Tavern Road, Suite 246, PO Box 3329, Mammoth Lakes, CA 93546
760-965-9897
Fax: 760-924-1831

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Mono County Health Department (26)
Jacinda Croissant, RN, BSN, PHNP.O. Box 3329, Mammoth Lakes, CA 93546
760-924-1842
Fax: 760-924-1831

COUNTY MENTAL HEALTH PLAN

Mono County Behavioral Health

1290 Tavern Rd Suite 276, Mammoth Lakes, CA 93546
800-687-1101
760-924-1740
Fax: 760-924-1741

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

Eastern Sierra Area Agency on Aging

1360 North Main Street, Suite 201, Bishop CA 93514-2709
760-873-3305
Fax: 760-878-0266

REGIONAL CENTERS

Kern Regional Center

3200 North Sillect Avenue Bakersfield, CA 93308
661-327-8531
Fax: 661-324-5060

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

760-924-4610

Sacramento County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and provider support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

The Public Programs Department interacts with public health departments and programs and works with participating providers and the DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

MEDI-CAL WAIVER PROGRAM

RX Staffing and Home Care, Inc.

4640 Marconi Ave., Ste. 3, Sacramento, CA 95821
916-979-7300

Sacramento County CCS Program
9616 Micron Ave., Ste. 970, Sacramento, CA 95827
916-875-9900
Fax: 916-854-9500

COMMUNICABLE DISEASE REPORTING

Sacramento County Public Health
700A E. Pkwy., Ste. 600, Sacramento, CA 95823
916-875-5881 (online reporting and setup assistance)
Fax: 916-854-9709

COMMUNITY-BASED ADULT SERVICES CENTERS

AltaMedix
4234 N. Freeway Blvd, Ste. 500, Sacramento, CA 95834
916-648-3999
Fax: 916-648-1919

California Association for Adult Day Services
1107 9th St., Ste. 701, Sacramento, CA 95814
916-552-7400
Fax: 866-725-3123

Eskaton Adult Day Health Care Center – Carmichael
5105 Manzanita Ave., Ste. D, Carmichael, CA 95608
916-334-0296
Fax: 916-348-6715

Help to Recovery – Easter Seals Superior California
3205 Hurley Way, Sacramento, CA 95864
916-485-6711
Fax: 916-485-2653

Rancho Cordova Adult Day Health Care Center
10086 Mills Station Rd., Sacramento, CA 95827
916-369-1113
Fax: 916-369-1138

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)
Sacramento County Department of Health and Human Services
9616 Micron Ave., Ste. 670, Sacramento, CA 95827
916-876-7750

Sacramento County Division of Behavioral Health Services
7001 A East Pkwy., Ste. 400, Sacramento, CA 95823
916-875-7070

Toll-free 24-hour information line
888-881-4881

REGIONAL CENTER
Alta California Regional Center
2241 Harvard St., Ste. 100, Sacramento, CA 95815
916-978-6400
Fax: 916-489-1033

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)
Community Resource Project WIC Program
916-326-5830

Sacramento County Department of Health and Human Services WIC Program
916-876-5000

SUBSTANCE ABUSE
Alcohol and Drug System of Care
Sacramento County Department of Health and Human Services
3321 Power Inn Rd., Ste. 120, Sacramento, CA 95826
916-874-9754

TB CONTROL PROGRAM
Sacramento County DHHS, Chest Clinic

Paul F. Hom Primary Care Center
4600 Broadway, Room 1300, Sacramento, CA 95820
916-874-9823
Fax: 916-854-9614

San Joaquin County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and provider support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

The Public Programs Department interacts with public health departments and programs and works with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

MEDI-CAL WAIVER PROGRAM

San Joaquin County Public Health Services
AIDS/Communicable Diseases Program
1601 E. Hazelton Ave., Stockton, CA 95205
209-468-3822
Fax: 209-468-8222

CALIFORNIA CHILDREN'S SERVICES (CCS)

San Joaquin County Public Health Services
2233 Grand Canal Blvd., Ste. 214, Stockton, CA 95207
209-468-3900
Fax: 209-953-3632

Mailing address
CCS Program, PO Box 2009, Stockton, CA 95201

COMMUNICABLE DISEASE REPORTING

San Joaquin County Public Health Services
1601 E. Hazelton Ave., Stockton, CA 95205
209-468-3822
Fax: 209-468-8222

MENTAL HEALTH PLAN

San Joaquin County Behavioral Health Services

1212 N. California St., Stockton, CA 95202

209-468-8700

Crisis intervention line 24/7

209-468-8686

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

San Joaquin County Human Services Agency

Aging and Community Services Bureau

102 S. San Joaquin St., Stockton, CA 95202

209-468-1104

Fax: 209-932-2613

REGIONAL CENTER

Valley Mountain Regional Center

702 N. Aurora St., Stockton, CA 95202

209-473-0951

Fax: 209-473-0256

SUBSTANCE ABUSE

San Joaquin County Behavioral Health Services – Substance Abuse Services

620 N. Aurora St., Ste. 1, Stockton, CA 95205

209-468-3800

Fax: 209-468-3723

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

San Joaquin County Public Health Services – WIC

620 N. Aurora St., Stockton, CA 95202

209-468-3281

Fax: 209-468-8573

Mailing address

San Joaquin County Public Health Services – WIC

PO Box 2009, Stockton, CA 95201

TB CONTROL PROGRAM

San Joaquin County Public Health Services

1601 E. Hazelton Ave., Stockton, CA 95205

209-468-3828

Fax: 209-468-8222

Stanislaus County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and provider support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

The Public Programs Department interacts with public health departments and programs and works with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

MEDI-CAL WAIVER PROGRAM

Stanislaus County Health Services Agency – Public Health
820 Scenic Dr., Modesto, CA 95350
209-558-7700
Fax: 209-558-4905

CALIFORNIA CHILDREN'S SERVICES (CCS)

917 Oakdale Rd., Modesto, CA 95353
PO Box 3088, Modesto, CA 95353-3088
209-558-7515
Fax: 209-558-7862

COMMUNICABLE DISEASE REPORTING

Stanislaus County Health Services Agency
Communicable Disease
Program
820 Scenic Dr., Modesto, CA
95353

Reporting Line
209-558-5678

COMMUNITY-BASED ADULT SERVICES CENTERS
Stanislaus County Health Services Agency
830 Scenic Dr., Modesto, CA 95350
209-558-7000

MENTAL HEALTH PLAN
Stanislaus County Behavioral Health and Recovery Services
800 Scenic Dr., Modesto, CA 95350
888-376-6246

Emergency Services
1501 Claus Rd., Modesto, CA 95355
209-558-4600
Fax: 209-557-6388

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)
Stanislaus County Community Services Agency
251 E. Hackett Rd., Modesto, CA 95353
209-558-2346
Fax: 209-558-2681

REGIONAL CENTER
Valley Mountain Regional Center
702 N. Aurora St., Stockton, CA
95202
209-473-0951
Fax: 209-473-0256

SUBSTANCE ABUSE
888-376-6246

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)
Stanislaus County Health Services WIC Program
251 E. Hackett Rd., Modesto, CA 95358
209-558-7377
Fax: 209-558-1244

TB CONTROL PROGRAM
820 Scenic Dr., Modesto, CA 95350
209-558-7700
Fax: 209-558-5014

Tulare County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and provider support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

The Public Programs Department interacts with public health departments and programs and works with contracting providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

PUBLIC HEALTH AGENCIES

COMMUNITY-BASED ADULT SERVICES CENTER

To obtain information about the nearest CBAS center, go to the California Department of Aging (CDA) website at www.aging.ca.gov.

AIDS CASE MANAGEMENT

Tulare County Health and Human Services Agency
1062 South K St., Tulare, CA 93274
559-685-5790
Fax: 559-685-3391

CALIFORNIA CHILDREN'S SERVICES (CCS)

1062 South K St., Tulare, CA 93274
559-685-5800
Fax: 559-713-3740

COMMUNICABLE DISEASE REPORTING

Tulare County Department of Health Services
1150 South K St., Tulare, CA 93274
559-685-5720
Fax: 559-687-6938

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

1062 South K St., Tulare, CA 93274

559-685-2275

MENTAL HEALTH PLAN – ADULT HEALTH SERVICES
559-624-7445

Emergency or crisis
800-320-1616

Youth Mental Health Services
Porterville
559-788-
1200

Tulare
559-688-2043

Visalia
559-627-1490

MULTIPURPOSE SENIOR SERVICES PROGRAM
4031 W. Noble Ave., Visalia, CA 93277
559-623-0199
800-321-2462

REGIONAL CENTER
Central Valley Regional Center
4615 N. Marty Ave., Fresno, CA 93722
559-276-4300
Fax: 559-276-4360

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)
New WIC appointments and client line
800-360-8840

Porterville Clinic
1055 W. Henderson Ave., Ste. 5, Porterville, CA 93257
800-360-8840

SUBSTANCE ABUSE
Alcohol and Drug Treatment
559-636-4000

TB CONTROL PROGRAM
559-685-5715

Tuolumne County

PROVIDER RELATIONS

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
hn_provider_relations@healthnet.com

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review Compliance Department provides one-to-one education and support.

21281 Burbank Blvd., Woodland Hills, CA 91367
209-943-4803
Fax: 877-779-0753
Facility.site.review@healthnet.com

HEALTH EDUCATION

The Health Education System provides no-cost culturally and linguistically appropriate health education programs and resources to support members and the community to achieve optimal physical and mental health.

21281 Burbank Boulevard, Woodland Hills, CA 91367
800-675-6110
Fax: 800-628-2704

PUBLIC PROGRAMS DEPARTMENT

Public programs administrators interact with public health departments and programs and work with participating providers and DHCS in administering public health programs and services.

800-526-1898
Fax: 866-922-0783

Public Health Agencies

CALIFORNIA CHILDREN'S SERVICES (CCS)

County Department of Health
20111 Cedar Road North, Sonora, CA 95370-5939
209-533-7404
Fax: 209-533-7406

COMMUNICABLE DISEASE INVESTIGATION PROGRAM

County Department of Health, Communicable Disease Control
20111 Cedar Road N., Sonora, CA 95370
209-533-7401
Fax: 209-533-7406

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Tuolumne County Health Department (55)
Amberly Hall
20111 Cedar Rd. N., Sonora, CA 95370
209-533-7401
Fax: 209-533-7406

COUNTY MENTAL HEALTH PLAN
2 South Green St., Sonora, CA 95370-4618
800-630-1130
209-533-6245
Fax: 209-533-7007

MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)
Area 12 Agency on Aging
19074 Standard Road, Sonora, CA 95370
209-532-6272
Fax: 209-532-6501

REGIONAL CENTERS
Valley Mountain Regional Center
702 North Aurora Street Stockton, CA 95202
209-473-0951
Fax: 209-473-0256

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
209-533-7434

CHAPTER 2 – ENROLLMENT AND DISENROLLMENT

Confusion about Medi-Cal managed care eligibility criteria and enrollment processes can hinder provision of health services to eligible Medi-Cal beneficiaries. This chapter describes the processes for enrollment and disenrollment, auto- assignment of a member to a primary care physician (PCP), and how to verify member eligibility.

Enrollment Criteria for Medi-Cal Managed Care

MANDATORY AID CATEGORIES

Under the Medi-Cal managed care program, enrollment is mandatory for most families and children who are eligible for Medi-Cal without a share-of-cost. These include:

- People who receive CalWORKs.
- Medically needy families with no share-of-cost Medi-Cal.
- Medically indigent children.
- Refugees or entrants.
- Most Medi-Cal-eligible seniors and persons with disabilities (SPD).

VOLUNTARY AID CATEGORIES

Beneficiaries who fall into these categories may enroll in a Medi-Cal plan, but are not required to do so:

- Children in adoptive aid programs.
- CalWORKs foster children.
- Medically indigent adults.

EXEMPTIONS FROM MANDATORY ENROLLMENT

To qualify for an exemption from plan enrollment, a Medi-Cal beneficiary must satisfy one of the following conditions:

- Be an American Indian who has been accepted to receive health care services from an Indian health service facility on a fee-for-service (FFS) basis (commonly referred to as an Indian Health Program exemption).
- Be under treatment for a complex medical condition from a Medi-Cal provider who is not participating with any Medi-Cal managed care plan's provider network in the beneficiary's county of residence (commonly referred to as a medical exemption). To qualify for a medical exemption, a beneficiary must be:
  - Pregnant.
  - Under evaluation for an organ transplant or approved for and awaiting a transplant.
  - Receiving chronic renal dialysis treatment.
  - HIV-positive or diagnosed with AIDS.
  - Diagnosed with cancer and currently receiving a course of accepted therapy, such as chemotherapy or radiation.
  - Diagnosed with another complex or progressive disorder not listed above, such as cardiomyopathy or amyotrophic lateral sclerosis (ALS), and is already in treatment.
  - Enrolled in a Medi-Cal waiver program that allows the beneficiary to receive subacute, acute, intermediate, or skilled nursing care at home rather than as an inpatient (known as a waiver exemption). Currently, four Medi-Cal waiver programs apply:
    - Medi-Cal Waiver.
    - Assisted Living Waiver.
    - In-Home Medical Care Waiver.
    - Nursing Facility/Acute Hospital Waiver.

NOT PERMITTED TO ENROLL

Medi-Cal beneficiaries who meet the following criteria are not permitted to enroll in a Medi-Cal managed care plan:

- Those in a skilled nursing facility (SNF) for 30 days past the month of admission*.
- Those with primary health coverage under:
  - TRICARE.
  - Other HMO.
  - Medicare HMO (unless Medicare HMO is also a Medi-Cal Plan and the Department of Health Care Services (DHCS) allows this plan to enroll beneficiaries in both the contractor's Medicare and Medi-Cal plan)*.

Member Enrollment Process

DHCS established the Health Care Options (HCO) referral process to provide Medi-Cal beneficiaries with information on the benefits of receiving health care services through managed care plans and to help the beneficiary choose a managed care plan. The HCO enrollment contractor is also responsible for assigning beneficiaries who do not choose a health plan on the Medi-Cal Choice form.

INITIAL ELIGIBILITY OR ANNUAL REDETERMINATION

The HCO enrollment contractor sends an enrollment packet to most Medi-Cal beneficiaries. The enrollment packet contains provider directories, a health plan comparison chart, enrollment instructions, a Medi-Cal Choice form, and a Medi-Cal Choice booklet.

MEDI-CAL CHOICE FORM

The beneficiary must select a health plan in their designated county and complete and mail back the Medi-Cal Choice form to the HCO enrollment contractor or call the HCO enrollment contractor to submit the choice via phone within 30 days of receiving the Medi-Cal Choice form from an HCO enrollment contractor. If the beneficiary does not select a health plan, the HCO enrollment contractor assigns one based on DHCS criteria.

HEALTH PLAN ENROLLMENT ASSISTANCE

The beneficiary may contact the Medi-Cal health plan of choice for more information about the plan or PCP code. For questions – or assistance in connecting with the HCO enrollment contractor to submit the choice via phone – the beneficiary can call the Health Net Enrollment Department at 800-327-0502.

AUTO ASSIGNMENTS TO THE HEALTH PLAN

The HCO enrollment contractor notifies the applicant or beneficiary in writing of the assignment to a Medi-Cal plan at least 10 business days prior to submitting the documents to DHCS. If the assignment is not appropriate or if the beneficiary wishes to enroll in a different Medi-Cal plan, the beneficiary must contact the HCO enrollment contractor to enroll in another Medi-Cal health plan. If a beneficiary chooses a health plan but neglects to choose a PCP, the health plan will automatically assign a PCP.

PCP SELECTION CRITERIA

Newly enrolled members must choose a PCP within 30 days from the time they become a member of Health Net. If the member does not select a PCP, Health Net will choose one within 10 miles or 30 minutes of the member's residence. The member can choose the same PCP or different PCPs, for all family members within Health Net, if the PCP is available.

If the member has a doctor they want to keep, or if the member wants to find a new PCP, they can go to the Provider Directory for a list of all PCPs and other providers in the Health Net network. The Provider Directory has other information to help the member choose a PCP. If the member needs a Provider Directory, the member can

call the Member Services Department at 800-675-6110 (TTY or 711). The member may also find the Provider Directory on the Health Net website at www.healthnet.com.

* Not applicable in Coordinated Care Initiative (CCI) counties, such as San Diego and Los Angeles.

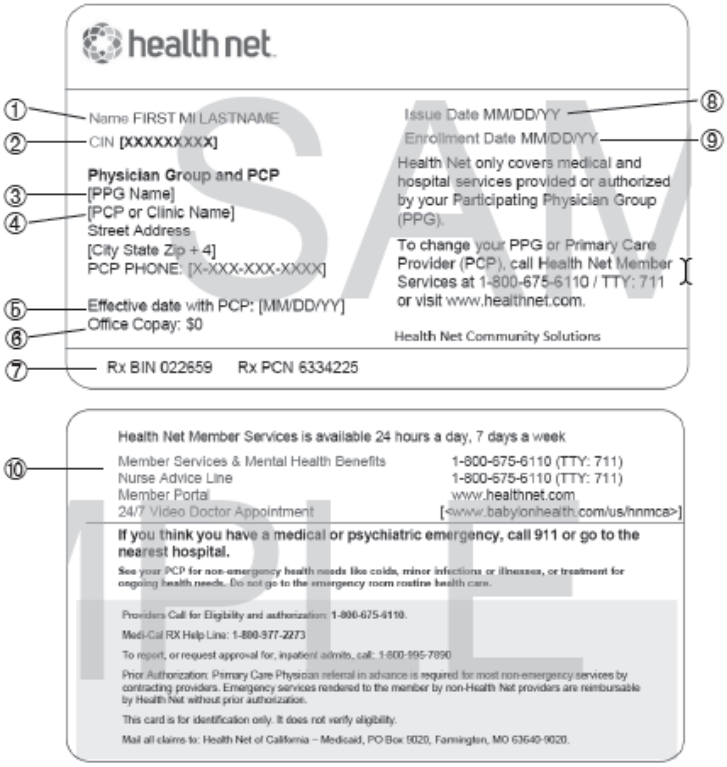
IDENTIFICATION CARD AND MEMBER MATERIAL DISTRIBUTION

Health Net sends new members a welcome letter and packet, which includes the *Evidence of Coverage (EOC)*, provider directory, preventive care services, and other important plan information. The materials are in the language preference indicated by the member. The identification (ID) cards and the new member packets are mailed within seven days of the member's effective date of enrollment.

MEDI-CAL MEMBER IDENTIFICATION CARD

ID Card Components

1. Member Name – Name of member
2. Member ID – State-assigned client index number (CIN)
3. Group Name – Participating physician group (PPG) name, if applicable
4. PCP Information – Name, address, and phone number of the member's assigned primary care physician (PCP) or federally qualified health center (FQHC)/rural health clinic (RHC), if applicable
5. Effective Date with PCP – Date the member was assigned to the PCP or FQHC/RHC, if applicable
6. Copayments – Out-of-pocket expense the member is required to pay for covered services (varies by plan)
7. Pharmacy Information – Contact and claims information for prescription medication processing vendor
8. Issue Date – Date the ID card was issued
9. Enrollment Date – Date the member was enrolled with Health Net Medi-Cal
10. Important Phone Numbers – Health Net contact phone numbers



MEMBER IDENTIFICATION NUMBER

Health Net has adopted the client index numbers (CINs), issued by DHCS, as the ID numbers for all Health Net Medi-Cal managed care members. The CIN is formatted as an alphanumeric code, beginning with eight digits followed by a letter.

Member Disenrollment Process

A member may disenroll at any time and without cause by contacting the HCO enrollment contractor, who will issue disenrollment forms directly to the member.

Members in a mandatory aid code must simultaneously re-enroll in another health plan, or the HCO enrollment contractor will enroll them in a health plan. Members in non-mandatory aid codes may choose a new health plan or return to the Medi-Cal FFS program.

Disenrollment of a member is mandatory when:

- Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the Federal lock-in option, if applicable.
- Member’s eligibility for enrollment with the health plan is termed or eligibility for Medi-Cal has ended, including the death of the member.
- Member's enrollment violated state marketing and enrollment laws, and DHCS or member requested dis-enrollment.
- Member requests disenrollment as a result of plan merger or reorganization.
- Member moves out of the plan's approved service area.
- Member's Medi-Cal aid code changes to an aid code not covered under the health plan.
- Health Net continues to be responsible for the member's health care until disenrollment is approved by the Department of Health Care Services (DHCS), not the plan. The disenrollment request may take 30 days to complete.

PROVIDER REQUESTS TO DISENROLL A NON-COMPLIANT MEMBER

To request disenrollment of a member, providers must contact the Health Net Medi-Cal Member Services Department. Providers are asked to describe the circumstances leading them to request the member non-compliant disenrollment and may be asked to submit documentation regarding their requests.

On notification, the Medi-Cal Member Non-Compliant Unit, the Customer Service Advocate (CSA) will reassign the member to a new PCP within the Plan.

A provider-initiated member non-compliant disenrollment request based on the breakdown of the provider-member relationship is considered good cause, only if one or more of the following circumstances occur:

- The member is repeatedly verbally abusive to plan providers, ancillary or administrative staff, or other plan members.
- The member physically assaults a plan provider, staff person or plan member, or threatens another person with a weapon. In this instance, the provider is expected to file a police report and bring charges against the member at the time of the incident.
- The member is disruptive to provider operations in general.
- The member habitually uses providers not affiliated with Health Net for non-emergency services without required authorizations.
- The member has allowed fraudulent use of the Health Net identification card to receive services from Health Net providers.
- The member is non-compliant with prescribed medication or treatment.
- The member has multiple missed appointments.

Provider non-compliant request is a formal written complaint from a contracted provider (PCP, PPG, specialists, Health

Care Services, other Health Net units) against a member who exhibits inappropriate behavior. The Provider is required to fax a detailed letter regarding the member non-compliance incident including specific details such as:

- Who: (member full name and Cin#)
- What: (type of non-compliance)
- When: (dates and times)
- Where: (Did the incident take place?)

The letter must provide details of what the provider has done to manage the member's behavior such as providing the member with education, to bring them back into complying. This includes referrals to pain management, case management, mental health etc.

If the letter is not received within 30 days from the time the non-compliance incident is reported to the health plan, the case will be closed.

Formal letter and all supporting document's must be faxed or mailed to:

Attn: Non-Compliance Unit
Fax: (844) 837-5947
Address: PO BOX 10303 Van Nuys, CA 91410-0303

Eligibility Reports

Health Net generates eligibility reports twice a month to provide information about member assignments to participating physician groups (PPGs) and hospitals. Providers who have questions or would like to order reports should contact the Health Net Medi-Cal Provider Services Department or the affiliated health plan's provider inquiry department.

Health Net also generates additional reports for providers participating directly with Health Net to help with scheduling required 120-day initial health appointments and preventive, well-child screening exams. Consult the Health Net Medi-Cal provider operations manuals for details.

Verifying Eligibility

Before providing care to a person seeking medical attention, providers must attempt to determine the person's eligibility as a Health Net member. Although member eligibility is verified at the time the ID card is issued, possession of the card at the time of service does not guarantee eligibility. If eligibility is not verified by the health care provider and services are provided to an ineligible person, Health Net does not accept financial responsibility for any services performed.

ELIGIBILITY VERIFICATION SYSTEMS

Eligibility can be verified using one of the following options:

- Health Net's provider portal at provider.healthnetcalifornia.com.
- Health Net's Provider Services Department at 800-675-6110.
- Point of Service (POS) device.
- Affiliated Computer Services (ACS)
- Claims and eligibility real-time systems (CERTS).

- TransUnion® MedConnect website at www.meddatahealth.com/login.aspx or by phone at 800-633-3282.
- Provider's clearinghouse.

Consult the Health Net Medi-Cal provider operations manuals for details.

Provider Enrollment Requirement through DHCS

Providers who wish to participate in Health Net's Medi-Cal network must be enrolled in Medi-Cal through the Department of Health Care Services (DHCS) in an approved status in accordance with DHCS regulations.

Monitoring and Enrollment

Health Net continues to monitor Medi-Cal enrollment status for participating providers, and first-tier, downstream and related entities (FDRs). In addition, delegated participating physician groups (PPGs) who are contracting with Health Net must verify that their network of providers involved in servicing Medi-Cal members are enrolled in Medi-Cal through DHCS.

DHCS enrollment applications can be located by provider type at www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx.

Chapter 3 – Access to Care

This chapter summarizes standards and processes for member access to primary care, specialty care, urgent and emergency care, and confidential and sensitive services. Referrals and authorizations for coverage of care are also covered.

Primary Care Access Standards

APPOINTMENTS AND REFERRALS

Members are instructed to call their primary care physician (PCP) directly to schedule appointments for routine care, except in the case of a life-threatening emergency. The PCP is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice.

ACCESS AND AVAILABILITY STANDARDS

The following access and availability standards have been developed to monitor the availability of timely health services to members. All standards are from the date of the member's request unless otherwise noted. The plans monitor these access standards to confirm compliance.

Medical Care Appointment Access Standards

Type of care	Standard
Emergency care	Immediately
Urgent care visit with a PCP	Appointment within 48 hours of request
Urgent care visit with SCP	Appointment within 96 hours of request
Non-urgent/routine care appointment with a PCP	Appointment within 10 business days of request
Non-urgent care appointment with a specialist	Appointment within 15 business days of request
First prenatal visit with a PCP or specialist	Appointment within 2 weeks of request
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request
Well-child visit	Appointment within 2 weeks of request
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Rural and small counties: Within 14 calendar days of request. Medium counties: Within 7 business days of request. Large counties: Within 5 business days of request
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues. Appropriate after-hours emergency instructions
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes
Provider office phone callback for non-urgent issues during normal business hours	Provider callback within 1 business day
Phone answer time at provider's office	Within 60 seconds

Behavioral Health Appointment Access Standards (Applies to behavioral health providers only)

Type of care	Standard
Access to life-threatening emergency	Immediately
Non-life threatening emergency	Within 6 hours
Urgent care	Within 48 hours
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization	Appointment within 48 hours of request
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization	Appointment within 96 hours of request
Non-urgent care appointment with non-physician behavioral health care provider for routine care	Appointment within 10 business days of request
Non-Urgent appointment with behavioral health care physician (psychiatrist) for routine care	Appointment within 15 business days of request
Non-urgent follow-up appointment with non-physician behavioral health care provider	Within 10 business days of request
Rescheduled Appointments	Appointment was scheduled to member's satisfaction

The following access standards also apply:

- In-office wait time for scheduled appointments must not exceed 30 minutes.
- The PCP or designee must be available 24 hours a day, seven days a week.
- Phone service must be available 24 hours a day, seven days a week.
- During office hours, office staff must answer 90% of phone calls within 60 seconds and return member phone calls within one business day.
- After office hours, physicians must return phone calls and pages within 30 minutes.

INTERPRETER SERVICES

In order to comply with applicable federal and state laws and regulations, providers are required to coordinate interpreter services, if needed, with scheduled appointments. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services. To allow sufficient time for scheduling, providers must request interpreter services at least five business days prior to the member's appointment. For sign language requests, please request this at least 10 business days prior to the member's appointment.

Health Net offers 24-hour access to interpreter services at no cost. Use phone interpreter services for same day appointments or when an in-person interpreter is not available. To obtain interpreter services, members and providers can contact Health Net Member Services at the phone number located on the member's ID card.

FACILITY ACCESS FOR THE DISABLED

Health Net and its participating provider and practitioners do not discriminate against members who have physical disabilities. Participating providers are required to provide reasonable access for disabled members in accordance with the Americans with Disabilities Act of 1990 (ADA). The Department of Health Care Services (DHCS) requires assessment of the physical accessibility for all PCP offices, high volume specialists, ancillary providers, Community-Based Adult Services (CBAS) providers, and hospitals.

The facility review process (refer to Chapter 8 for facility site review information) includes the Physical Accessibility Review Survey (PARS). The PARS assessment summarizes the physical accessibility for the provider site into levels of access (basic and limited) and specific accessibility indicators.

Accessibility indicators include access to parking, exterior building, interior building, including elevators, restrooms, examination rooms, medical equipment (accessible weight scales and adjustable examination tables), participant areas, and patient diagnostic areas.

Results of the PARS are made available to Health Net's Medi-Cal Member Services Department and listed in the provider directory to assist members in selecting a PCP who can best serve their health care needs.

AFTER-HOURS ACCESS

Health Net requires physicians, or a registered nurse under physician supervision, to maintain 24-hour phone coverage seven days a week through their answering service or 24-hour on-site medical care for members. PPGs and PCPs who do not have services available 24 hours a day may use an answering service (live answering or automated) to provide members with clear and simple instruction on after-hours access to medical care. This information is vital in case of an urgent or emergency situation or if there is a need to contact a physician after normal business hours. Health Net has sample scripts available in the Health Net Provider Library. Physicians must return after-hour phone calls and pages within 30 minutes.

EMERGENCY PHONE NUMBERS

Emergency and poison control phone numbers must be posted near the office or facility phones.

Access to Confidential and Sensitive Services

This section provides general information about members' access to sensitive and confidential services. Additional detailed information about sensitive services, confidentiality standards and consent requirements are described in Chapter 5.

FREEDOM OF CHOICE

Medi-Cal members have the freedom of choice to receive timely and confidential family planning services, diagnosis and treatment for sexually transmitted infections (STIs), and HIV counseling and testing services from any family planning provider without prior authorization. Further, members may receive timely and confidential referrals for drug and alcohol treatment services.

SENSITIVE SERVICES

Sensitive services include those services related to treatment for injuries resulting from sexual assault, drug or alcohol abuse treatment, pregnancy, family planning, HIV counseling and testing, pregnancy termination, outpatient mental health treatment and diagnosis, residential shelter services, intimate partner violence, and treatment of sexually transmitted infections (STIs) for children under age 18.

COVERAGE AND SERVICES

Members may access sensitive services in a timely manner and without barriers. Prior authorization is not required for access to certain services. Members may access most sensitive services from any qualified provider, in- or out-of-network, except obstetrical care for pregnancy and services related to substance abuse and mental health. The PCP should encourage members to access in-network providers for services whenever possible. This process improves coordination of care and has a positive impact on health outcomes. Out-of-network providers must demonstrate reasonable efforts to coordinate services with a member's PCP or obtain the member's written refusal to do so.

Members should receive medical care according to the nature of the medical problem. The member or PCP should make the determination of timely access. Members can receive family planning services, including pregnancy testing, STI diagnosis and treatment, and HIV counseling and testing from participating or nonparticipating providers as outlined in Chapter 5.

Obstetrical care for pregnancy must be accessed through an in-network provider (pregnancy testing is considered a family planning service and may be obtained from any qualified provider in- or out-of-network). Refer to the discussion of Pregnancy and Maternity Care in Chapter 4 for additional information.

Drug and alcohol abuse treatment services are carved out from Health Net's coverage responsibilities. These services are covered, administered and paid for by sources other than Health Net. Neither Health Net nor its PPGs are responsible for payment of these services. Refer to the discussion of Alcohol and Drug Treatment Services in Chapter 6 for additional information.

Members under age 18 may access and obtain minor consent services without parental consent and without prior authorization for such sensitive services as family planning, sexual assault (including rape) and pregnancy services (including pregnancy termination). Refer to the discussion in Chapter 5 on Minor's Consent for Services, categorized by age, for additional information about these and other sensitive services such as drug and alcohol abuse and mental health.

CONFIDENTIALITY

Health Net employees and participating providers must maintain the confidentiality of member information pertaining to the member's access to these services.

Nurse Advice Line

The nurse advice line is staffed 24 hours a day, seven days a week by registered nurses for member assistance. The program offers services in conjunction with the PCP's services and does not replace the PCP's instruction, assessment and advice.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, provide self-care guidance, general health information, or recommend a visit to urgent care or the ER. Standard triage protocols are utilized, which have been written and reviewed by physicians.

The nurse advice line is Utilization Review Accreditation Commission (URAC) accredited and provides phone triage using industry-approved triage protocols. The triage or screening services are monitored to coincide with state standards including the following access measures:

- 100% of calls are handled in 30 minutes (1800 secs).
- ≤ 5% of calls are dropped prior to being handled.

Physicians may direct members to contact the nurse advice line through the Health Net Member Services phone number found on the back of the member's identification (ID) card.

SUBCONTRACTING PLANS' TRIAGE PROGRAMS

In Los Angeles County, Health Net's subcontracting plan, Molina, provides similar nurse triage programs for members whose PCP is contracting through Molina. Molina providers must direct their Health Net members to use the triage program of their respective plan.

Emergency and Urgent Care

Emergency services are covered under this health plan in the United States, Canada or Mexico. An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the

woman or her unborn child, or

- Serious impairment to bodily function, or
- Serious dysfunction of any body organ or other part.

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or treat an emergency medical condition.

URGENT CARE

Urgent care is required for those medical conditions that do not fit the definition of emergency, but require the member to receive treatment within 48 hours (for Medi-Cal facility site review purposes, within 24 hours).

PHONE ASSESSMENT

Phone assessment of member health problems and follow-up may only be performed by licensed staff (physicians, registered nurses and nurse practitioners) and in accordance with established standards of practice.

Community-Based Adult Services

Community-Based Adult Services (CBAS) provides a variety of health, therapeutic and social services to eligible Medi-Cal members ages 18 and older.

CBAS services are delivered based on need and an established care plan, offering a bundle of services during a service day. The number of days per week that members receive services is based on medical criteria and is included in their Health Net-approved Individual Plan of Care (IPC). Services include, but are not limited to:

- Skilled nursing care.
- Social services.
- Personal care.
- Physical, occupational and speech therapy.
- Family and caregiver training and support.
- Meals.
- Mental health services.
- Transportation to and from the CBAS center.

Members who may benefit from CBAS are those with multiple complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring, skilled nursing and therapeutic intervention, and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short- or long-term nursing facility admission.

REFERRAL PROCESS

Participating providers, case managers, registered nurses, and licensed social workers who believe a Health Net member may benefit from the CBAS program must request a face-to-face assessment. The request is made by submitting the CBAS request form via fax to the CBAS Request Line at 833-581-5908 to initiate a face-to-face assessment and arrange transportation to and from the center for assessment.

Health Net completes an initial face-to-face assessment using the CBAS Eligibility Determination Tool (CEDT) to determine eligibility for CBAS. Once eligibility is validated, Health Net notifies the CBAS center to complete the evaluation of service needs and develop an IPC. The CBAS center submits the evaluation and IPC, signed by all

appropriate team members, to Health Net for authorization or notification of services and number of days per week the member is eligible for services.

Prior authorization or notification is required for CBAS. Refer to Prior Authorization Requirements for additional information.

Long-Term Services and Supports (LTSS) Non-Urgent Appointment

As required by DHCS, time access standards will be established for services when the provider travels to the member and/ or community locations to deliver services. Timely access references the number of business days or calendar days from the date of request that an appointment must be available within the type of service. Standards for skilled nursing facilities (SNF) and intermediate care facilities (ICF) are based on county population density as follows:

- Rural counties: Within 14 calendar days of request.
- Small counties: Within 14 calendar days of request.
- Medium counties: Within seven business days of request.
- Large counties: Within five business days of request.

Mental Health Services

Health Net Medi-Cal members obtain the following mental health services:

- Non-specialty mental health services (NSMHS):
  - Mental health evaluation and treatment, including individual, group and family psychotherapy.
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
  - Outpatient services for purposes of monitoring drug therapy.
  - Psychiatric consultation.
  - Outpatient laboratory, drugs, supplies and supplements.
- Medications for Addiction Treatment (MAT), also known as medication-assisted treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

Members do not need to contact their PCPs, PPGs or attending physicians to request referrals for mental health care office visits. Members may obtain mental health office visits directly through our extensive behavioral health network by calling the member services phone number listed on their ID cards. Providers may also contact Health Net for assistance with mental health services referrals (refer Medi-Cal members assigned to Molina Healthcare to Molina for mental health services).

PCPs are responsible for coordinating referrals for members who require specialty or inpatient mental health services to the county mental health plans (CMHPs). Each county is required to provide access to specialty mental health services for Medi-Cal members. Refer to the Specialty Mental Health Services discussion in Chapter 6 for additional information.

BEHAVIORAL HEALTH THERAPY SERVICES

Behavioral health therapy (BHT) services may include psychiatric services, such as medication management of specific symptoms related to autism spectrum disorders (ASD), as well as any comorbid psychiatric conditions;

family therapy to help parents and siblings cope with the diagnosis and the member with ASD behaviors; brief psychotherapy to teach behavior modification techniques to parents to assist them in managing their child; and individual psychotherapy for adolescents and young adults with an ASD. Inpatient hospitalization may also be necessary if the child with ASD becomes an acute danger to self or others, or is behaviorally disruptive, requiring intensive intervention to stabilize the individual.

BHT services are administered by Health Net. Providers may submit treatment referrals to Health Net by calling the member services phone number on the back of the member's identification (ID) card.

REFERRAL COORDINATION

PCPs are responsible for referring Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens-eligible members identified as needing BHT services, regardless of diagnosis, to Health Net for assessment and referral to a mental health provider. Health Net manages the behavioral health benefits of Medi-Cal members.

BHT services may include, but are not limited to:

- Applied behavioral analysis.
- Individual or family training.
- Client/parent support behavioral intervention training.
- Adaptive skills trainer by a qualified BHT provider.

Dyadic Services

Dyadic Services denote a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified. Dyadic services include dyadic behavioral health (DBH) well-child visits, dyadic comprehensive community support services, dyadic psychoeducational services, and dyadic family training and counseling for child development. The DBH well-child visit is provided for both child (members under age 21) and parent(s)/caregiver(s) together, preferably within the pediatric primary care setting the same day as the medical well-child visit. Dyadic services screen for behavioral health problems, interpersonal safety, tobacco and substance misuse and social drivers of health (SDOH), such as food insecurity and housing instability, and include referrals for appropriate follow-up care.

Facilities or clinics that offer integrated physical health and behavioral health services, such as Community Health Centers and Federally Qualified Health Centers (FQHCs), are able to conduct the medical well-child visit, the DBH well-child visit and some or all of the ongoing dyadic services. Physicians who do not offer integrated behavioral health services are able to initiate dyadic services by conducting the medical well-child visit and making referrals to behavioral health providers, for the DBH well-child visit and ongoing dyadic services.

ELIGIBILITY REQUIREMENTS

Members under age 21 and their parent(s)/caregiver(s) are eligible for DBH well-child visits when:

- Delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment.
- Medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Medi-Cal for Kids & Teens standards.
- The child must be enrolled in Medi-Cal. The parent(s) or caregiver(s) does/do not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.

Referrals to Dyadic services providers

Referrals can be made to the following dyadic services providers:

- Licensed clinical social workers.
- Licensed professional clinical counselors.
- Licensed marriage and family therapists.
- Licensed psychologists.
- Psychiatric physician assistants.
- Psychiatric nurse practitioners.
- Psychiatrists.

Claims billing

Refer to the table below for dyadic services and billing codes. Encounters for dyadic care services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

Dyadic Services	Description/Billing Codes
Services for members under age 21 (when billed to the child's Medi-Cal ID with the modifier U1)	• Dyadic behavioral health (DBH) well-child visits: H1011. • Dyadic comprehensive community support services, per 15 minutes: H2015 (separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports). • Dyadic psychoeducational services, per 15 minutes: H2027. • Dyadic family training and counseling for child development, per 15 minutes: T1027.
Services for parent/caregiver (services provided to the caregiver for the benefit of the child during a child's visit, and billed using the child's Medi-Cal ID with the modifier U1)	• ACE screening: G9919, G9920 • Alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT): G0442, H0049, H0050. • Brief emotional/behavioral assessment: 96127. • Depression screening: G8431, G8510. • Health behavior assessments and interventions: 96156, 96167, 96168, 96170, 96171. • Psychiatric diagnostic evaluation: 90791, 90792. • Tobacco cessation counseling: 99406, 99407.

Transportation

Transportation services to and from medical appointments for medically necessary covered services are available to all Medi-Cal members. Coverage is limited to the least costly medical transportation that is adequate for the member's medical needs.

Use the Physician Certification Statement (PCS) Form – Request for Transportation form to document the specific transportation restrictions of a member due to a medical condition when requesting non-emergency medical transportation (NEMT) for Medi-Cal members. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com. A PCS form is not required for non-medical transportation (NMT).

NON-EMERGENCY MEDICAL TRANSPORTATION

NEMT is a covered service only when the patient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated. Additionally, NEMT is covered for patients who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (ambulatory door to door). This includes door-to-door assistance for all members receiving NEMT services. NEMT modalities, in accordance with the Medi-Cal Provider Manual, are:

- NEMT ambulance which includes:

  - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
  - Transfers: 1) from acute care facility to another acute care facility, immediately following an inpatient stay at the acute level of care, 2) to a skilled nursing facility or 3) an intermediate licensed care facility.
- Litter van when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets the need for both of the following:
  - The member must be transported in a prone or supine position because the member is incapable of sitting for the period of time needed for transport.
  - Specialized safety equipment is required over and above what is normally available in passenger cars, taxicabs or other forms of public conveyance.
- Wheelchair van medical transportation services when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
  - The member is incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
  - Members who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (ambulatory door to door).
  - The member must be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
  - Specialized safety equipment is required over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
- NEMT by air (requires Health Net authorization and Letter of Agreement) only under the following conditions:
  - Transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible.

NON-MEDICAL TRANSPORTATION

NMT includes round trip transportation by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), as well as mileage reimbursement (at the time transportation is arranged), bus passes, taxi vouchers, or train tickets for medical purposes.

Round trip NMT is available for the following:

- Medically necessary covered services.
- Members picking up medication prescriptions that cannot be mailed directly to the member.
- Members picking up medical supplies, prosthetics, orthotics, and other equipment.
- Dental services.
- Mental health services.
- Substance abuse services.
- All Medi-Cal covered services.

Access to Services in Primary Language

Members whose primary language has been identified as a threshold language by the Department of Health Care Services (DHCS) receive written information in that language from Health Net. Health Net monitors member access to information and services in threshold languages in many ways, including primary care site certification.

THRESHOLD LANGUAGES

A language is a threshold language for Medi-Cal purposes, when a population group of eligible beneficiaries residing in the MCP's service area who indicate their primary language as a language other than English and meet:

- A numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
- The concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

The current threshold languages by county are:

- Amador – English.
- Calaveras – English.
- Inyo – Spanish.
- Los Angeles – Arabic, Armenian, Chinese (Cantonese and Mandarin are written using traditional Chinese characters), Farsi, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese.
- Mono – Spanish.
- Sacramento – Arabic, Chinese, Farsi, Hmong, Russian, Spanish, and Vietnamese.
- San Joaquin – Chinese, Spanish.
- Stanislaus – Spanish.
- Tulare – Spanish.
- Tuolumne – English.

PCP RESPONSIBILITIES FOR CULTURAL AND LINGUISTIC SERVICES

Participating providers must ensure that they are distributing health education materials and providing interpreter services at all provider sites to all members who require or request them in any language. Federal and California state law require Medi-Cal providers to communicate in the primary language of their patients as a condition of participation under the Medi-Cal program. Participating providers should contact the Member Services Department to arrange interpreter support for members.

Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that interpreters are available at the time of the appointment.
- Ensure that members with limited-English proficiency (LEP) are not subject to unreasonable delays in the delivery of services, including accessing providers after hours.
- Provide interpreter services at no cost to members.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to members with LEP that are as effective as those provided to members without LEP.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in their medical records. Providers are strongly encouraged to document the use of any interpreter in the member's record.
- Provide translated member grievance forms to members upon request.

Members have the right to:

- Receive interpreter services at no cost.
- File a complaint or grievance if language needs are not met.
- Not use family members, friends, and minor children as interpreters.

Referrals for Specialty Care

The PCP is responsible for management and coordination of a member's complete medical care, including initial and primary care, maintaining continuity of care and initiating specialist referrals. The PCP refers the member to a specialist when additional knowledge or skills are required.

Health Net has delegated the referral process to some PPGs. Referrals to participating and nonparticipating specialists for members assigned to a delegated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose referral or authorization requirements that conflict with the member's right to self-refer.

SERVICES THAT DO NOT REQUIRE REFERRAL OR PRIOR AUTHORIZATION

Prior authorization is not required for the following services, and services may be obtained from any qualified in-network or out-of-network provider:

- Emergency services.
- Minor consent services.
- Abortion services may be obtained from any qualified in-network or out-of-network provider.
- Family planning, sexually transmitted infection (STI) diagnosis and treatment, HIV testing and counseling, and sexual assault services may be obtained from any qualified in-network or out-of-network provider.
- Drug and alcohol abuse treatment and mental health treatment - these services are not covered by Health Net's Medi-Cal managed care plan and may be obtained through the county drug and alcohol program and the county mental health program.

Referral and prior authorization are not required for Comprehensive Prenatal Services Program (CPSP) services. Services may be obtained from any participating CPSP providers.

Other services not requiring prior authorization include:

- Certain services for American Indian members, including:
  - An American Indian member can obtain covered services from an out-of-network Indian health care provider without requiring a referral from a network primary care provider (PCP) or prior authorization.
  - MOA 638 Indian Health Services facilities or providers, whether in the Plan's network or out-of-network, can provide referrals directly to network providers without a referral from a network PCP or prior authorization. An American Indian member may receive services from an out-of-network Indian health care provider even if there are in-network Indian health care providers available.
- Department of Health Care Services (DHCS) -required immunizations when provided from the local health department (LHD) (LHD must submit immunization records with any claim).
- Pregnancy care with a participating network obstetrician.
- Preventive services from a participating provider.
- Services for emergency medical conditions.
- Specialist referral to a participating specialist.
- Urgently needed services when the member is outside of their county.
- Certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider.
- Biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (must be FDA-approved).

REFERRALS TO SPECIALISTS – FEE-FOR-SERVICE (FFS) PROVIDERS

A referral is required for cases that are difficult to manage or when care is beyond the PCP's scope of practice.

When referring a member for specialty care, the directly participating FFS PCP must follow the guidelines outlined below:

- The PCP selects a specialist from the list of participating providers in Health Net's Medi-Cal provider listing. Providers may call the Provider Relations Department for assistance if there is difficulty finding an available in-network specialist from the Medi-Cal provider listing.
- For services with an out-of-network specialist, the PCP completes and faxes the Request for Prior Authorization form to the specialist with the authorization number attached. PCPs participating through a PPG must follow the PPG referral guidelines.
- If an out-of-network referral is necessary, due to medical necessity or patient need, even if a participating provider is closer, the referral benefit is at the member's in-network cost of share.
- For specialty visits with participating specialists, there is no need to complete a Request for Prior Authorization form or notify Health Net. However, many specialists prefer to have a completed Request for Prior Authorization form or an authorization number prior to performing services. As a courtesy to the specialist, Health Net provides the PCP with an authorization number upon request from the PCP or specialist.
- When scheduling an appointment, the wait time for specialty care must not exceed 96 hours for urgent care and 15 business days for non-urgent services and must be coordinated with the PCP based on the severity of the condition.
- The specialist treats the member as indicated on the Request for Prior Authorization form and notifies the PCP of the findings.
- The specialist may order diagnostic tests, X-ray and laboratory services, and durable medical equipment (DME). Some services may require prior authorization.
- If the member requires treatment beyond the services listed on the Request for Prior Authorization form, the specialist must contact the PCP for an additional referral.
- Referrals are only valid between participating providers. Any referrals to nonparticipating providers require prior authorization from the Medical Management Department, with the exception of those services for which members may self-refer without prior authorization.

Referrals between specialists are not generally covered. When a specialist determines that referral to another specialist is needed, the PCP should be notified and requested to make the referral.

REFERRALS TO SPECIALISTS – CAPITATED PROVIDERS

Health Net delegates the referral process to full and shared-risk PPGs. Referrals to participating and nonparticipating specialists for members assigned to a delegated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose referral or authorization requirements that conflict with the member's right to self-refer. A referral is required for cases that are difficult to manage or when care is beyond the PCP's scope of practice.

When referring a member for specialty care, the PCP must follow the guidelines outlined below, as well as those dictated by the PPG:

- The PCP selects a specialist who participates in the PPG.
- The PCP follows the PPG's referral guidelines.
- When scheduling an appointment, the wait time for specialty care must not exceed 96 hours for urgent care and 15 business days for non-urgent services and must be coordinated with the PCP based on the severity of the member's condition.
- The specialist treats the member as indicated on the referral and notifies the PCP of the findings.

- The specialist may order diagnostic tests, X-ray and laboratory services, and DME. The specialist must follow the PPG's referral guidelines and use the provider network when referring for lab, X-ray, DME and other ancillary services.
- If the member requires treatment beyond the services requested by the PCP, the specialist must contact the PCP for an additional referral, as required by PPG guidelines.

- Referrals are only valid between participating providers. Any referrals to nonparticipating providers require prior authorization from the PPG or Health Net or its affiliated health plans, depending on the PCP's contract affiliation.

RECEIPT OF SPECIALIST'S REPORT

The PCP must ensure timely receipt of the specialist's report. For Medi-Cal members, reports from specialty services for consultations or procedures should be in the member's chart within two weeks. If the PCP has not received the specialist's report within two weeks, the PCP should contact the specialist to obtain the report. For urgent and emergency cases, the specialist should initiate a phone report to the PCP as soon as possible, and a written report should be received within two weeks.

REFERRALS TO PUBLIC PROGRAMS

Many of the public programs require different referral and prior authorization processes. Refer to the applicable section of this guide for public program information. For greater detail, including services requiring prior authorization, providers should refer to the Health Net Medi-Cal provider operations manual for their county, located in the Provider Library.

PROVIDER RESPONSIBILITIES FOR REFERRAL TRACKING

Health Net's participating providers are required to monitor referrals that have been authorized for medically appropriate care to ensure that members access care and follow up with their PCPs.

PCPs are responsible for maintaining continuity of care for Health Net members during the referral process. This entails monitoring referrals made for their Health Net Medi-Cal members to ensure that appropriate services are accessed and pertinent specialty service reports are received for inclusion in the primary care medical record.

Health Net and its PPGs also have responsibilities for tracking referrals. Additional information about these responsibilities and the tracking systems in place is available in the Health Net Medi-Cal provider operations manuals located online in the Provider Library.

Prior Authorization Requests

Prior authorization ensures medical necessity of services, appropriate level of care and use of participating providers, as well as to prevent unanticipated denials of coverage.

Attending physicians are responsible for obtaining prior authorizations. Referrals from physicians cannot be substituted for prior authorizations from the Prior Authorization Department.

Providers contracting directly with Health Net (FFS providers) must obtain prior authorization from the Prior Authorization Department or as specified on the prior authorization requirements list. Health Net has delegated the prior authorization process to some PPGs and to the subcontracting health plan. Prior authorizations for members assigned to a delegated PPG are subject to any additional rules imposed by the PPG or subcontractor. PPGs or subcontractor health plans may not impose prior authorization or referral requirements that conflict with the member's right to self-refer for certain services.

REQUESTING PRIOR AUTHORIZATION – CAPITATED PROVIDERS

Providers participating through a delegated PPG must follow the PPG's prior authorization procedures. Contact the PPG for information.

PRIOR AUTHORIZATION PROCESS – FFS PROVIDERS

Health Net's streamlined prior authorization process for FFS providers enables them to coordinate medically necessary care in the most timely and efficient manner.

- Health Net does not require prior authorization for most common services, including referrals to Health Net participating specialists.
- Procedures performed in the member's PCP's or specialist's office do not require prior authorization, unless the procedure is included on the Health Net prior authorization requirements list.
- Prior authorization is required for elective inpatient admissions, elective surgical procedures (in either inpatient or outpatient setting) and for other services listed on the Prior Authorization Requirements list.
- Specialists are required to send copies of the consultation and treatment plans to the member's PCP.
- All participating providers are required to refer any services related to a California Children's Services (CCS)-eligible condition to the local county CCS agency for authorization.
  - CCS-eligible services must be provided by a CCS-paneled provider at CCS-approved facilities. Health Net is not responsible for authorization or payment for services related to a CCS-eligible condition.

REQUESTING PRIOR AUTHORIZATION

To request prior authorization:

- The PCP completes the Request for Prior Authorization form and sends it to the specialist. This ensures that the member is seeking services from in-network providers, helps monitor the care provided to members and provides instructions to the specialist regarding authorized services.
- The PCP and specialist retain a copy of the IP or OP prior authorization form in the member's chart.
- Fax a copy of the Request for Prior Authorization form to the Prior Authorization Department.
  - Providers are required to complete all fields on the form as follows to expedite the process of these requests.
  - This ensures that Health Net identifies case management needs and assists the member with coordination of care, when appropriate.
  - This also enables Health Net to assist in the detection of and referral to appropriate agencies for carve-out services, such as California Children's Services (CCS).
- Specialists submitting paper claims to Health Net must include a copy of the completed Request for Prior Authorization form with the claim.
  - This supports the PCP-to-specialist referral and helps avoid delays in payment.
- Specialists submitting electronic claims must indicate the name of the referring provider in box 23 of the CMS-1500 claim form.

The PCP or specialist provider must give the Prior Authorization Department as much advance notice as possible when requesting prior authorization. For routine elective inpatient or outpatient services, the provider must fax or mail requests for prior authorization at least five days before the anticipated date of service. Health Net strongly recommends that services not be scheduled prior to receiving the Medical Management Department review decision. This allows sufficient time to notify the provider of the review decision prior to the services being rendered.

Submission of Requests

For fax requests, the provider should fax the Request for Prior Authorization form to the Prior Authorization Department, as listed in Chapter 1 of this guide. Requests are processed Monday through Friday, 8 a.m. to 5 p.m. Providers may request blank forms by calling the Health Net Medi-Cal Provider Services Department.

Prior authorization requests may also be mailed to the Health Care Services Department. Clearly mark the envelope "Prior Authorization." Prior authorization requests for urgent services may be submitted by phone by calling the Medical Management Department. Requests for services that are not urgent must be submitted by fax or mail.

REQUIRED INFORMATION

The provider must give the following information when requesting prior authorization:

- Member's name.
- Member's ID number.
- Member's date of birth.
- Diagnosis.
- Requesting physician's name, phone and fax numbers, and contact person.
- Place where services are provided.
- Physician's name (physician receiving referral), ancillary provider name and facility name.
- Procedures.
- Date of service.

The Prior Authorization Department reviews the information and calls back with the review decision. If the service is authorized, an authorization number is given.

PRIOR AUTHORIZATION REQUIREMENTS

For a Health Net member assigned to a FFS PCP, providers are encouraged to access the county-specific provider operations manuals to obtain the most current prior authorization requirements. County-specific provider operations manuals are available in the Provider Library. Providers requesting services for a member assigned to a delegated PPG must consult the PPG for the PPG's prior authorization requirements.

Medication Prior Authorization Requests

Certain medications on the Medi-Cal Rx Contract Drug List (CDL) require prior authorization for coverage. Medications not found on the Medi-Cal Rx CDL may require prior authorization.

Prior Authorization can be requested in the following ways:

- By going to www.covermymeds.com.
- By logging into the portal and submitting the PA through our Prior Authorization tool. Login from the provider portal and access the secured Prior Authorization tool.
- By sending a completed PA form through fax to 800-869-4325.
- By submitting a NCPDP P4 Transaction through Pharmacy POS system.
- By sending a completed PA form through mail at:
  Medi-Cal Rx Customer Service
  Center Attn: PA Request
  PO Box 730
  Sacramento, CA 95741-0730

Phone: 800-977-2273

For additional information, please refer to the Medi-Cal Rx Options for PA Submission Guide at https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/bulletins/2020/12/B_Medi-Cal_Rx_Options_for_PA_Submission_Guide.pdf.

Chapter 4 – Medical Standards

Medi-Cal managed care members are entitled to services and exams that are intended to check maintain or improve a member's health. This chapter covers those medical standard service guidelines and programs required under the Medi-Cal managed care program, including Comprehensive Perinatal Services Program (CPSP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program coordination; preventive, well-child screening guidelines; Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services guidelines; American Academy of Pediatrics (AAP) guidelines; initial health appointments (IHAs); and adult preventive health screenings.

Several of the requirements include mandatory physician referral for certain specialty services. The Medi-Cal Referral Service Variations matrix, included on page 76, indicates requirements for mandatory referrals (additional designations for self-referral and sensitive services are covered in Chapter 5).

Preventive Care Services

Preventive care aims to prevent or reduce disease risk and to promote early detection of disease or precursor states. Medical services and supplies required for preventive care are to be provided to all members as directed by the primary care physician (PCP) or designee.

Preventive care service guidelines include:

- Routine pediatric and adult examinations and health screenings, newborn hospital visits, counseling and anticipatory guidance, developmental and behavioral assessments, screening diagnostic tests, and laboratory services.
- Routine pediatric immunizations recommended jointly by the AAP, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP).
- Routine adult immunizations recommended by ACIP.

PCP RESPONSIBILITIES

The primary care physician (PCP) is responsible for:

- Providing a comprehensive initial health appointments (IHA) to all new members within 120 calendar days after the member's date of enrollment.
- Completing ongoing health assessments as indicated by the periodicity table. Adult and senior assessments are completed every three to five years.
- Notifying members of periodic or clinically indicated appointments.
- Documenting assessment findings, treatments, recommendations, and follow-up in the member's medical record.
- Providing follow-up care, laboratory evaluation and specialty care if a medical condition warranting further care is found at the time of routine assessment.
- Coordinating care with specialists, including providing adequate clinical information to specialists to whom a member was referred for additional services.
- Making appointments for required assessments.
- Documenting missed or broken appointments in the member's medical record and following up with the member according to the procedure for missed or broken appointments.

FREQUENCY OF ROUTINE EXAMS

Age	Frequency
0–20	Refer to AAP Recommendations for Preventive Pediatric Health Care in the Medi-Cal Provider Operations Manual
19–25	Annually
26–39	Annually
40–49	Annually
50–65	Annually
65 and older	Annually

Initial Health Appointment

All Medi-Cal members ages 18 months and older must have an IHA, which includes the member's history (history of present illness, past medical and social history, and review of organ systems) and physical examination, within 120 calendar days after their date of enrollment. The IHA must be conducted in a culturally and linguistically appropriate manner for all members, including those with disabilities.

The member may be seen initially during a visit for episodic care. Regardless of the reason for the initial visit, the PCP should conduct the IHA at the first health care contact and document the assessment in the medical record.

Refer to PCP Responsibilities on page 80 for more information.

GUIDELINES

For members under age 21, the IHA and ongoing assessments must follow the current AAP Recommendations for Preventive Pediatric Health Care guidelines. The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the member is up to date with the Recommended Childhood Immunization Schedule based on joint recommendations of the Advisory Committee on Immunization Practices (ACIP), Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings. Providers must also ensure that members receive all screening, preventive and medically necessary diagnostic and treatment services required under the EPSDT benefit, as described by DHCS in the EPSDT Provider Information.

For members ages 21 and older, the initial appointment includes, but is not limited to, an evaluation and timely provision of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

IHA DOCUMENTATION AND REPORTING

For all providers, a member eligibility report is available through Health Net Membership Accounting at the primary care physician’s (PCP’s) request to allow providers to reach out to their new members and ensure completion of all appropriate preventive care services and the IHA within 120 calendar days. Providers must also have an established Health Net provider account to access the IHA reports on the Health Net provider website.

Health Net reviews monthly claims and encounter data of comprehensive initial health appointments rendered by participating providers. These encounters are cross-checked against member enrollment data. A member eligibility report is available at the PCP’s or participating physician group’s (PPG’s) request on a monthly basis to provide an aid for IHA compliance.

In all cases, the PCP must document all member contacts, including scheduling of the appointment or the member’s refusal to schedule an appointment, in the member’s medical record.

PCP COORDINATION

Health Net sends new members a welcome packet that includes an IHA notification and information about how to schedule an appointment with their PCPs. The IHA notification instructs new members to schedule an appointment with their PCPs.

PCPs must document all member contacts, including the scheduling of the IHA appointment or the member's refusal of an appointment in their medical record.

During the initial and subsequent health appointments, PCPs must inform members, parents or guardians about the need and importance of periodic health appointments and reinforce the member's understanding of the need for routine preventive, well-child screening services at each medical encounter. PCPs are encouraged to schedule the next visit at the conclusion of the member visit. PCPs are also encouraged to use an appointment reminder system. If PCPs identify a medical condition during the IHA, diagnosis and treatment must begin within 60 calendar days. Justification for any delays beyond 60 calendar days must be documented in the member's medical record. If an appointment is scheduled, but missed or broken, the PCP must follow the procedure for missed or broken appointments.

COORDINATION BY HEALTH NET

Health Net sends new members a welcome packet that includes an initial health appointments (IHA) notification, provider directory, *Evidence of Coverage (EOC)*, preventive care services, and other important plan information. Instructions are included for new members to schedule appointments with their PCPs. Health Net contacts new Medi-Cal members by phone after mailing the new member packet to communicate the importance of scheduling an IHA and to share other relevant information about members using their benefits. If the IHA has not occurred within 45 days of enrollment, Health Net conducts a third member contact via phone. If a member, or the parent or guardian of a child member, refuses to have the IHA performed, it must be documented in the member's medical record.

In all cases, the PCP must document all member contacts, including scheduling of the appointment or the member's refusal to schedule an appointment, in the member's medical record.

Preventive and Screening Services for Children and Youth Under Age 21

Some preventive and screening services previously provided by the Child Health and Disability Prevention (CHDP) program will continue to be provided by the Managed Care Plan (MCP). Health Net provides preventive, well-child screening services to children and youth under age 21. These services encompass the requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Medi-Cal for Kids & Teens program, and aim to prevent childhood disability by screening children during critical times of growth and development and making referrals as necessary to improve their health.

PROVIDER CERTIFICATION REQUIREMENTS

Providers of pediatric primary care services must be enrolled in the Medi-Cal program. Medi-Cal enrollment is offered at no charge to providers by the Department of Health Care Services (DHCS) Provider Enrollment Division (PED). Non-Medi-Cal-enrolled providers may obtain enrollment information by contacting DHCS or, go to the DHCS Provider Application and Validation for Enrollment.

Due to the Child Health and Disability Program (CHDP) transition, physicians and other providers enrolled and active the CHDP Gateway on June 30, 2024, are automatically enrolled in the Children's Presumptive Eligibility (CPE). Additional information about the transition can be found on the CHDP Program Transition website.

Physicians and other providers not active in CHDP as of June 30, 2024, must complete steps to meet eligibility requirements to become enrolled as a Medi-Cal provider and then a CPE provider. After enrolling in Medi-Cal and receiving approval, providers can take the above training to participate in CPE as of July 1, 2024.

APPOINTMENTS AND REFERRALS

Medi-Cal members requesting an appointment with their PCP or mid-level provider must be scheduled for an appointment within 10 business days if the child is behind schedule for a preventive, well-child screening exam. If the PCP cannot provide the needed services within 10 business days, the PCP may refer the member to another participating provider, out-of-network well-child screening services provider, local health department (LHD), or school-based well-child screening services program. A PCP referring a member to an out-of-network provider must furnish a complete referral.

If an external source (for example, school, member or out-of-network provider) contacts the Health Net Medi-Cal Member Services Department, a representative contacts the member's PCP to determine whether the member is in need of current preventive, well-child screening services and to assist with appointment scheduling, if needed.

DENTAL CARE

All children with dental problems must be referred directly to a Denti-Cal dentist for care. All members ages three and older must be referred annually for preventive dental care to a dentist who accepts Denti-Cal, regardless of whether a dental problem exists. Providers or members may call Denti-Cal for a list of three Denti-Cal providers in the member's ZIP Code. Providers in Los Angeles County may call their affiliated health plan's provider inquiry unit for direction on dental referrals and dental networks. The PCP is also responsible for dental assessments. Refer to the discussion of Dental Screenings on page 67 for more information.

COORDINATION OF CARE

The PCP is responsible for supervising physician extenders, providing ongoing care, and coordinating all services the member receives. The provider must verify any suspected serious medical conditions (for example, heart murmur, scoliosis and developmental problems). When needed services fall outside the PCP's scope of practice, referrals must be made and treatment initiated within 60 days of the initial health appointment at which the condition was identified. The Medical Management Department is available to provide coordination, if indicated by the member's condition and requested by the PCP.

Physician extenders may not be barriers to a request to see a physician. Any member being cared for by a physician extender must be given an appointment with the PCP without having to work through the physician extender.

If members in need of transportation assistance do not meet the criteria for non-emergency transportation, the PCP refers the member to Public Programs for assistance with transportation.

OBTAINING CONSENT

Providers must obtain the voluntary written consent of the member, parent or guardian before performing a preventive, well-child screening exam. Consent is also required for any release of medical information. A standard consent form (PM 211) is available to providers who do not have their own consent form for release of information.

If the member or member's parent or legal guardian refuses to have the exam or any portion of it performed, this information must be documented in the member's medical record.

CERTIFICATION FOR SCHOOL ENTRY

California law requires that children entering first grade must provide their schools with a certificate documenting that they have had a preventive, well-child screening exam or a waiver of the exam signed by the parent or guardian. The exam may be done up to 18 months prior to or within 90 days after entrance into first grade. Providers should give the parent or guardian of a child entering kindergarten or first grade a certificate documenting that the child has received the appropriate health exam. A child may be certified without a preventive, well-child screening exam if the child has received a physical exam and ongoing comprehensive medical care from that physician during the 18-month period prior to or within 90 days following entrance into the first grade.

Health Net and local schools urge parents to obtain a health assessment for their child on entry into kindergarten. If a health assessment is refused by the parent or guardian, the parent or guardian must submit a waiver to the school.

The Advisory Committee on Immunization Practices (ACIP) has formally adopted an exception to its recommendation for MMR vaccination, now allowing administration of the MMR to children up to four days prior to their first birthday. California state laws regarding school entry, however, preclude this exception for children in California. Children in California who receive the MMR immunization prior to their first birthday are required to be re-immunized prior to entrance into first grade.

FOLLOW-UP FOR MISSED APPOINTMENTS

No-show appointments must be followed up with a phone call/text/email or a letter from the provider's office staff to the member's parent or guardian requesting the scheduling of another appointment. Place a copy of the letter and documentation of any follow-up attempts in the member's medical record.

CMS-1500 FORM CODING INSTRUCTIONS

For fee-for-service (FFS) physicians, preventive and screening services for children and youth under age 21 are billed on a CMS-1500 form using appropriate CPT/HCPCS codes. The XX indicator "3" must also be entered in the box 24H (EPSDT/Medi-Cal for Kids & Teens/family planning) of the CMS-1500 form to indicate that the visit was for preventive and screening services.

For capitated physicians, the preventive and screening services for children and youth under age 21 must be reported as a Medi-Cal encounter to Health Net for reporting to DHCS.

Appropriate CPT and HCPCS procedure codes for CMS-1500 forms and encounters are listed on the next page. Note that health assessment services are included in payment for the office visit and are not separately payable.

PHYSICIAN OFFICE PREVENTIVE AND SCREENING SERVICES

Procedure description	CMS-1500 CPT/HCPCS procedure code
Physical exam, new patient, birth–11 months	99381
Physical exam, new patient, 1–4 years	99382
Physical exam, new patient, 5–11 years	99383
Physical exam, new patient, 12–17 years	99384
Physical exam, new patient, 18+ years	99203–99205
Physical exam, established, birth–11 months	99391
Physical exam, established, 1–4 years	99392
Physical exam, established, 5–11 years	99393
Physical exam, established, 12–17 years	99394
Physical exam, established, 18+ years	99203–99205
Dental assessment	Included in exam fee
Nutritional assessment	Included in exam fee
Anticipatory Guidance Health Education	Included in exam fee
Developmental assessment	Included in exam fee
Snellen or equivalent 3–6 years	Z2702
Snellen or equivalent 7+ years	Z2702
Audiometric	92552
Hemoglobin or hematocrit	85013–85018
Urine dipstick	81000
Complete urinalysis	81005
TB multipuncture	No longer covered
TB Mantoux – TB patch or intradermal	86580
TB Mantoux – TB Tine	86585
Sickle Cell: Electrophoresis handling fee	Z5218
Lead: Blood lead handling fee	Z5220
VDRL, RPR, ART handling fee	86593
G.C. Culture handling fee	Z5220
Pap test handling fee	Z5220
PKU: Blood handling fee	84030
Chlamydia culture handling fee	Z5220
Pelvic exam	57410
MMR/MuR/MR immunization	90707**
Measles immunization	90705**
Rubella immunization	90706**
Hib CV immunization	90655,** 90657, 90658
Polio (IPV) immunization	90713**
Hepatitis B immunization, low dose, pediatric/adolescent, three doses	90744**
HBIG immunization	90748**
Hepatitis B immunization, high dose, adolescent, two doses	90743**
DTaP	90700**
Varicella, VFC	90716**
MMR, Non-VFC, 19–20 years	90707
Hepatitis B, Non-VFC, 19–20 years	90746
Varicella, Non-VFC	90716

**Only immunization administration fees are payable; vaccines are obtained free of charge by the provider from the Vaccines for Children (VFC) program.

Procedure description	CMS-1500 CPT/HCPCS procedure code
Influenza, VFC	90655,** 90657, 90658
Influenza, Non-VFC, 19–20 years	90656
Pneumococcal, Non-VFC	90732
Hepatitis B/Hib, VFC	90748**
HBIG free balance	90371
TB Adult PF	90714
DT pediatrics	90702
Td adult	
Hib	90645, 90646, 90647, 90648, 90737
Polio-inactivated	90712
Hepatitis A, Non-VFC, 2–18 years	90632,** 90633, 90634
Hepatitis A, Non-VFC, 19–20 years	90632
Prevnar, VFC	90669
Pediarix	
Meningococcal conjugate	90734
Flu mist	90660
Tdap	90715
MMRV	90710
Rotavirus, pentavalent	90680
Human papillomavirus (HPV)	90649
Influenza preservative free	90654, 90655, 90656
Rotavirus, 2 doses	90681
DTap-Hib-IPV	90698
DTap-Hib	90721
Bivalent human papillomavirus	90650
Pneumococcal 13-valent conjugate (PCV13), VFC	90670

**Only immunization administration fees are payable; vaccines are obtained free of charge by the provider from the Vaccines for Children (VFC) program.

LAB PREVENTIVE AND SCREENING SERVICES***

Procedure Description	CMS-1500 CPT/HCPCS Procedure Code
Sickle Cell: Electrophoresis	83020
Lead: Blood lead level types (Pb test)	83655
VDRL, RPR, ART	86593
Gonorrhea culture (GC)	87076
Pap test	88150–88155
Chlamydia culture	87100
Pelvic exam	57410
Ova and/or parasites test	87177
Lead test: lead counseling and blood draw	Z0334
Lead referral – counseling and referral for blood drawing for lead testing	
Blood glucose	82947–82950, 82962
Total cholesterol	83718-83719

***These services are payable only to labs. Physicians may bill for collection and handling only.

COORDINATION OF SERVICES WITH SCHOOL-BASED PROGRAMS

Health Net's policy on routine preventive, well-child screening services to children under age 21 is that they are provided principally by the member's PCP for the following reasons:

- These services are the PCP's basic responsibility.
- All members have an assigned PCP who can provide these services.
- Provision of these services by the member's PCP promotes continuity of care.

Health Net has entered into contracts and agreements to provide and coordinate health care services where school-based clinics operate under the auspices of a Health Net PPG. Members who are identified at school sites as needing preventive and screening services may receive these services from the contracting school-based clinics within the required state and federal time frames. Health Net follows up and documents that preventive and screening services are provided to members. Health Net's participating school-based clinics and PCPs provide health assessments in accordance with the most recent AAP periodicity schedule for preventive health services.

All members who are identified at school sites as needing preventive and screening services are to receive these services from their PCPs within the required state and federal time limits. If the member's PCP is unable to provide the needed exam within 14 days of the request when the exam is overdue, the PCP may refer the member to another Health Net provider, out-of-network provider, LHD, or PPG-linked school-based clinic.

EPSDT/Medi-Cal for Kids & Teens Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Medi-Cal for Kids & Teens services for Medi-Cal members under age 21 are based upon members identified health care needs. Diagnostic and treatment services are provided to treat, correct or ameliorate any physical or behavioral conditions by the appropriate provider or organization. The EPSDT/Medi-Cal for Kids & Teens program allows for periodic medically necessary screening and appropriate preventive, mental health, developmental, vision, hearing, dental, and specialty services. For Medi-Cal members under age 21, dental screening or assessment must be performed at every periodic assessment. EPSDT/Medi-Cal for Kids & Teens services include case management and targeted case management services designed to assist children in gaining access to necessary medical, social, education, and other services.

Health Net's Health Care Services staff or delegated participating physician group (PPG) coordinates with PCPs to identify children under age 21 who would benefit from these services and assist with appointment scheduling. Health Net determines medical necessity of EPSDT/Medi-Cal for Kids & Teens services according to the criteria established by DHCS. When the EPSDT/Medi-Cal for Kids & Teens services are provided for the California Children's Services (CCS) program or are specialty mental health services (which are carved out from Health Net's coverage responsibilities), Health Net does not determine medical necessity.

Health Net's Health Care Services staff or delegated PPG ensures that members under age 21 who qualify for EPSDT/Medi-Cal for Kids & Teens services are referred to an EPSDT/Medi-Cal for Kids & Teens services provider or to an entity that provides EPSDT/Medi-Cal for Kids & Teens services, such as a regional center. If these referred providers render EPSDT/Medi-Cal for Kids & Teens care management services, the care manager and Health Net medical director or delegated PPG medical director determine medical necessity. If EPSDT/Medi-Cal for Kids & Teens care management services are not available from these referral providers, the health plan or delegated PPG arranges and pays for EPSDT/Medi-Cal for Kids & Teens services.

According to Department of Health Care Services (DHCS) All Plan Letter (APL) 18-007: Medi-Cal managed care health plans (MCPs) and delegated PPGs are to provide all medically necessary Medi-Cal covered services while EPSDT/Medi-Cal for Kids & Teens program eligibility is pending. The EPSDT/Medi-Cal for Kids & Teens benefit is more robust than the Medi-Cal benefit package required for adults, and states may not impose limits on EPSDT/Medi-Cal for Kids & Teens services and must cover services listed in Section 1905(a) of the Social Security

Act (SSA) regardless of whether or not they have been approved under a state plan amendment. Also, according to Title 22, California Code of Regulations (CCR) Section 51340, the MCPs and delegated PPGs must provide or arrange and pay for all medically necessary services otherwise covered by EPSDT/Medi-Cal for Kids & Teens (case management services and other services), if services are not available from EPSDT/Medi-Cal for Kids & Teens providers and the services are expressly not covered in the plan's DHCS contract.

REFERRALS

In most cases, PCPs identify members in need of EPSDT/Medi-Cal for Kids & Teens services as part of regular health screening visits. The need for services may also be identified by the member, the member's parents or other family, or by an encounter with another health care provider. Providers must direct all referrals for EPSDT/Medi-Cal for Kids & Teens services to Health Net's Health Care Services Department or delegated PPG.

Health Net's Health Care Services staff and Health Net's Medi-Cal medical directors or delegated PPG medical directors review requests and determine medical necessity for EPSDT/Medi-Cal for Kids & Teens services.

PCPs are responsible for referring EPSDT/Medi-Cal for Kids & Teens-eligible members identified as needing behavioral health therapy (BHT) services, regardless of diagnosis to Health Net for assessment and referral to a mental health provider. Health Net manages the behavioral health benefits of Medi-Cal members. BHT services may include, but are not limited to:

- Applied behavioral analysis.
- Individual or family training.
- Client/parent support behavioral intervention training.
- Adaptive skills training by a qualified BHT provider.

CARE COORDINATION

Health Net's Health Care Services staff or the delegated PPG works in coordination with the Health Net Public Programs Department to monitor the appropriate use of local government organizations, including regional centers, that provide EPSDT/Medi-Cal for Kids & Teens services. The Medical Management staff or delegated PPG coordinates with the member's PCP to monitor that referrals are made to the proper agencies and programs. Following review and authorization by a Health Net medical director or the delegated PPG medical director, Health Net's Health Care Services staff or the PPG coordinates the services with the PCP.

If EPSDT/Medi-Cal for Kids & Teens services are not available through a local government agency or organization, Health Net's Health Care Services staff or the delegated PPG issues letters of authorization and negotiated claims payment instructions to EPSDT/Medi-Cal for Kids & Teens services providers, and continues to provide care coordination services, including assistance in scheduling appointments, arranging non-medical transportation and non-emergency medical transportation to and from medical appointments and updating the care management plan. Health Net must ensure that appropriate EPSDT/Medi-Cal for Kids & Teens services are initiated in a timely manner, as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for a follow-up.

DOCUMENTATION

The member's medical record must reflect the following regarding EPSDT/Medi-Cal for Kids & Teens case management services:

- Member and family education regarding EPSDT/Medi-Cal for Kids & Teens services.
- Referral to EPSDT/Medi-Cal for Kids & Teens case management services.
- Reason for referral.

- Member or family response to referral.
- Subsequent case management plan.

PROBLEM RESOLUTION

Health Net's Case Management Department resolves disputes that arise regarding responsibility for necessary EPSDT/Medi-Cal for Kids & Teens services. Health Net's Medical Management staff or the delegated PPG continues to coordinate and authorize all immediate health care needs in collaboration with the PCP until the matter is resolved.

Private Duty Nursing Services

Private duty nursing (PDN) services are available for Medi-Cal members under age 21 pursuant to the EPSDT/Medi-Cal for Kids & Teens benefit. PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.

When PDN services support a California Children's Services– (CCS-) eligible medical condition, the provider must submit a Service Authorization Request (SAR) with clinical documentation to the local CCS program office. CCS will authorize a SAR for the requested services if medical necessity criteria are met.

PDN CASE MANAGEMENT/CARE COORDINATION RESPONSIBILITIES

When an eligible member under age 21 is approved for PDN services and requests that the health plan or delegated PPG provide case management services for those PDN services, the health plan or delegated PPG's obligations include, but are not limited to:

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled home health agencies and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible home health agencies and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
- Working with enrolled home health agencies and enrolled individual nurse providers to jointly provide PDN services to the member.

Members may choose not to use all approved PDN service hours, and acceptance of available PDN services is at the member's discretion. The health plan and delegated PPGs are permitted to respect the member's choice. The member's record must document instances when a member chooses not to use approved PDN services.

REQUIREMENT FOR PDN SERVICES

PDN services require an authorization for all members under age 21.

- If the PPG is delegated for utilization management, the PPG is responsible for completing the authorization.
- If the PPG's member is receiving PDN services through CCS, CCS is responsible for the authorization.
- Whoever completes the authorization must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

All members under 21 receiving PDN services must be case-managed.

Providers must submit a referral to the health plan's Case Management Department for members under 21 receiving PDN services approved by the PPG, and for their members receiving PDN services through CCS or another entity.

Providers can submit a referral to the health plan's Case Management Department by completing and submitting a

case management referral form via email to CASHP.ACM.CMA@healthnet.com or by fax to 866-581-0540. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References*.

Adverse Childhood Experiences (ACEs) Screening

Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences people have by age 18, such as abuse, neglect and household dysfunction.

Screening for ACEs can help determine if a patient is at increased health risk due to a toxic stress response and provide trauma- informed care. Identifying and treating cases of trauma in children and adults can lower long-term health costs and support the well-being of individuals and families.

The California Department of Health Care Services (DHCS) has identified and approved specific screening tools for children and adults for the 10 categories of ACEs grouped under three sub-categories: abuse, neglect and household dysfunction. The tools are available at www.acesaware.org/screen/screening-tools/.

Childhood Blood Lead Screening

Providers must perform blood-lead level (BLL) testing and follow-up services in accordance to the guidelines issued by the Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB). Blood-lead level testing is required for children at ages 12 months and 24 months or when documented evidence of a BLL test is missing for a child up to age 12–72 months. Evidence of the parent or guardian's refusal of lead screening must be documented in the child's medical record. Providers must also document anticipatory guidance in the child's medical record by using DHCS suggested CPT codes 83655 (lead test) with one of the following 99401, 99402, 99403 or 99404 (preventative medicine counseling). Oral or written anticipatory guidance to a parent or guardian of the child should include, at a minimum, information that children can be harmed by exposure to lead, especially from deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk from the time the child begins to crawl. Providers must obtain a signed statement of voluntary refusal by the parent or guardian, or document reasons for not obtaining the signed statement (i.e. parent refused or is unable to sign, assessment done via telehealth, etc.). PCPs are responsible for providing the parents or guardian of a child age 6–72 months education on risks to lead exposure. Blood-lead level screenings results must be electronically reported to the CLPPB.

Immunizations

PCPs are responsible for administering immunizations to members. LHDs may also immunize Medi-Cal members.

ADMINISTRATION OF IMMUNIZATIONS

PCPs are responsible for administering immunizations to members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize Health Net Medi-Cal members. The Department of Health Care Services (DHCS) requires participating providers to document each member's need for Advisory Committee on Immunization Practices (ACIP)-recommended immunizations as part of all regular health visits and to report the administration of immunizations within 14 days.

They are also responsible for updating the state-supplied yellow card (PM 298) immunization record or other immunization record used.

At each visit, the PCP should ask if the patient has received immunizations from another provider. The PCP should also educate members about their responsibility to inform the PCP if they receive immunizations elsewhere (for example, from a nonparticipating provider or LHD). This information is necessary for documentation and for the member's safety. Providers must enroll in and use the California Immunization Registry (CAIR) website at CAIRweb.org to report and track patient immunization records online.

Local Health Department

In accordance with DHCS guidelines, Health Net reimburses LHDs for certain immunizations given without prior authorization. The LHD is responsible for verifying the member's immunization status, as it will not be reimbursed for immunizations provided when the member's immunizations are current. LHDs must submit a copy of the member's immunization record with the claim form. On request, Health Net assists LHDs with obtaining the member's immunization history and forwards a copy of the member's immunization record to the member's PCP for inclusion in the member's medical record.

If the member receives an immunization from the LHD and complications occur, the member must contact the PCP for care as with any other medical problem.

VACCINES FOR CHILDREN PROGRAM

Providers are required to enroll in the Vaccines for Children (VFC) program, a federally funded program providing immunizations to physicians serving Medi-Cal-eligible patients. It furnishes free vaccines in bulk to enrolled providers for Medi-Cal-eligible children under age 19. To participate in the VFC program, complete the forms that are available at www.cdc.gov/vaccines/programs/vfc/index.html

MEMBER OUTREACH AND EDUCATION

Health Net's member outreach and health education programs inform members about the importance of immunizations, immunization schedules and the need to preserve immunization records. Members receive this information in their new member packet, member newsletter, immunization reminder postcards, and any other communication channels as appropriate.

REIMBURSEMENT

For immunizations of members 19 and older, Health Net reimburses FFS providers at the Medi-Cal FFS program rate, which includes an allowance for the vaccine and its administration.

SERVICE COORDINATION TEAM

Health Net's Service Coordination Team works with LHDs to facilitate the exchange of data and information.

Dental Screenings

Medi-Cal members are entitled to dental screenings/oral health assessments, as described in the periodic health exam schedule (refer to the Medi-Cal Provider Operations Manual in the Health Net Medi-Cal Provider Library for periodic health exam schedules).

Dental services other than dental screenings are not covered under Health Net's Medi-Cal contracts. Health Net is not financially responsible for covering dental services under any circumstances, including when they are provided as an EPSDT/Medi-Cal for Kids & Teens service. Health Net's participating PCPs refer members for dental services to Medi-Cal dental providers.

Health Net covers the following medical services related to non-covered dental services:

- Contractually covered prescription medications.
- Medically necessary laboratory services.
- Pre-admission physical examinations required for admission to an outpatient surgical center or an inpatient hospitalization required for a dental procedure.
- Facility fees for inpatient and outpatient services (such as ambulatory surgery center) that are prior authorized.
- Physician or certified registered nurse anesthetist administered anesthesia services such as intravenous (IV) moderate sedation and deep sedation/general anesthesia for inpatient and outpatient services.

- Covered medical services related to dental services that are not provided by dentists or dental anesthetists.
- Fluoride varnish, up to three times in a 12-month period, for Medi-Cal members under age 6.

PCP RESPONSIBILITIES

The PCP must conduct a dental assessment for members under age 21 to check for normal growth and development and the absence of tooth and gum disease at the time of the IHA and at each preventive, well-child screening examination visit according to the periodic health examination schedules.

A dental screening for children under age three includes, but is not limited to, an examination of the mouth and gums and anticipatory guidance on proper feeding practices and on cleaning the mouth to remove bacteria. For children over age three, the screening includes, but is not limited to, an examination of the mouth, teeth and gums; prescription for fluoride supplementation if drinking water is not adequately fluoridated; and anticipatory guidance in the prevention of dental caries, orofacial injury and disease; proper oral hygiene practices; and consideration of dental sealants.

PCPs are also responsible for performing a dental screening exam on adult members as part of the IHA and at scheduled periodic health assessments and to encourage them to receive an annual dental exam. All screenings, referrals and the reason for the referral must be documented in the member's medical record.

MANDATORY REFERRAL

The PCP must make a mandatory dental referral following the member's initial dental health screening starting at age three, or earlier, if dental problems are identified and continue to refer the member on subsequent, annual dental health screenings if warranted at the time by any new or ongoing dental issues identified. The PCP must provide a topical fluoride varnish to the member's teeth during their exam. A referral to a dentist or orthodontist should be made if the member has severe malocclusion within six months of the first tooth erupting or no later than the member's first birthday. All screenings, referrals and the reason for the referral must be documented in the member's medical record.

Providers or members may call Denti-Cal at 800-322-6384 for a list of three Denti-Cal providers in their ZIP Code.

Routine Eye Examinations and Eyewear

The PCP is the primary screener for ocular abnormalities requiring referral for a comprehensive eye examination. Comprehensive eye examinations performed by an optometrist or ophthalmologist are covered for all Medi-Cal members.

Providers should refer to the Health Net Provider Directory for a list of participating optometrists and ophthalmologists. Providers should contact the Health Net Medi-Cal Provider Services Department to obtain the most current directory.

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at about age 3. Children between ages four and six should have a comprehensive eye examination in addition to the screening performed by the PCP. Children with prescription eyewear or contact lenses should have an eye examination annually.

The following vision services are covered under Medi-Cal plans:

- Routine eye examination and refraction every two years (service date to service date) for members.
- Second eye examination with refraction within two years is covered only when the criteria for replacement lenses and the following criteria are met:
  - The member is unable to return to or obtain the prescription from the previous provider.

  - The examination is necessary to determine a change in vision.
- Annual diabetic retinal eye examinations by an ophthalmologist or optometrist for members who have been diagnosed with diabetes.
- Medically necessary eye examinations by an ophthalmologist or optometrist for acute or urgent care.
- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus. Adults ages 21 and older are covered for bandage contacts only when medically necessary; other ophthalmological materials are not covered.

FRAMES AND LENSES

Optical lenses and frames are covered every two years for all members.

POLYCARBONATE LENSES

Polycarbonate lenses are covered for the following:

- Member is age 18 or younger.
- Member is over age 18 who meets of the following requirements:
  - Visual impairment in one or both eyes where the optimal correction is equal to or less than 0.30 decimal or 20/60 Snellen or equivalent at specified distances.
  - Either visual field is limited to ten degrees or less from the point of fixation in any direction.

Note: Optical lenses are made by California Prison Industry Authority (CalPIA) optical laboratories and provided with cost through the optometrist's or ophthalmologist's office participating with Centene Vision Services for those identified above.

FRAME REPLACEMENT AND REPAIR

- Replacement within two years of initial coverage is limited to the same model whenever feasible.
- Replacement frames within two years are not covered if an existing frame can be made suitable for continued use by the following:
  - Adjustment.
  - Repair of broken frame.
  - Replacement of broken frame part.

*REPLACEMENT LENSES**

Replacement is covered when:

- The power is changed at least 0.50 diopters in any corresponding meridian.
- The cylinder axis is changed 20 degrees or greater for cylinder power of 0.50–0.62 diopters, 15 degrees or greater for cylinder power of 0.75–0.87 diopters, 10 degrees or greater for cylinder power of 1.00–1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12–0.37 diopters, as the sole reason for change, is not covered.
- The prismatic differential correction is changed at least 0.75 prism diopters in the vertical meridian or at least 1.5 prism diopters in the horizontal meridian.
- The previous lens is lost, stolen, broken, or marred to a degree significantly interfering with vision or eye safety.
- A different frame size or shape is necessary due to patient growth, metal allergy or other justifiable medical reasons.

*Replacement lenses should be ordered directly through the CalPIA optical laboratories.

LOW VISION EXAMINATIONS AND AIDS

Low vision examinations and aids (including the fitting) are covered if:

- The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point.
- The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means.
- The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient.
- The aid prescribed or provided is the least costly type that will meet the needs of the recipient.

EXCLUSIONS

The following are not covered:

- Eyeglasses used primarily for protective, cosmetic, occupational or vocational purposes.
- Eyeglasses prescribed for reasons other than the correction of refractive errors or binocularity anomalies.
- Progressive lenses.
- Orthoptic and/or pleoptic training.
- Prescription eyeglasses for alternative use by a person who has and is able to wear contact lenses.
- Upgraded frames or non-standard lenses, unless when meeting medical necessity.
- Prosthetics (may be covered by the health plan/medical group).
- Surgical professional services normally performed by an ophthalmologist (may be covered by the health plan/ medical group).
- Multifocal contact lenses.

Pregnancy and Maternity Care

Members may see any qualified participating Health Net provider within their PPG, including their PCP, OB/GYN, or certified nurse midwife (CNM) and certified nurse practitioner (CNP), for prenatal care. PPGs or PCPs and specialists are prohibited from requiring a referral or prior authorization for basic prenatal care. Medi-Cal members have the right to receive covered nurse midwife services from any Medi-Cal freestanding birth centers (FBCs) and to services provided by CNMs and licensed midwives (LMs) without referral or prior authorization. If there are no CNMs or CNPs in the PPG network, access to non-contracting CNMs or CNPs is a benefit.

All pregnant members must have access to Comprehensive Perinatal Services Program (CPSP) services that integrate health education, nutrition and psychosocial services with obstetrical care. CPSP support services providers are required to use the DHCS-approved assessment tools. Health Net has developed assessment tools approved by DHCS that are included in the Forms and References section of the Provider Library. The multidisciplinary approach to the delivery of perinatal care in the CPSP framework is based on the recognition that providing these services from conception through 60 days following delivery improves pregnancy outcomes.

The provision of CPSP services to pregnant members is the responsibility of CDPH-certified CPSP providers who contract with Health Net, a subcontracting health plan or a PPG.

Health Net PPGs must maintain and reimburse a network of obstetric and community providers who are CPSP-certified in order to promote access to the CPSP program and improve birth outcomes for their patients. PPGs may not redirect CPSP services away from contracting CPSP-certified providers who are in good standing with the state and local county CPSP program. CPSP-certified providers must be allowed to provide services to Health Net Medi-Cal members. Health Net and CDPH attempt to have all obstetricians providing care to Medi-Cal members become CPSP-certified, to allow CPSP services to be provided during routine obstetric prenatal and postpartum visits.

PREGNANCY CARE MANAGEMENT

The initial prenatal examination must occur within two weeks (for Medi-Cal facility site review purposes, within seven calendar days) of the initial referral or request for pregnancy-related services. The obstetric provider is expected to provide care for members using standards consistent with current American College of Obstetricians and Gynecologists (ACOG) recommendations and within accepted Health Net guidelines.

Obstetric care providers are responsible for identifying high-risk pregnancy candidates and referring them to perinatal specialists, coordinating other medically necessary services, and making referrals to social services and community support agencies at any time during the pregnancy when high risk indicators are identified.

Pregnant members are assigned a facility for delivery. The obstetric provider forwards a copy of the member's prenatal care records in accordance with the facility's procedures.

MATERNAL MENTAL HEALTH SCREENING REQUIREMENT

Assembly Bill (AB) 2193 requires licensed health care practitioners who provide prenatal or postpartum care for a patient to screen or offer to screen mothers for maternal mental health conditions.

Providers serving Health Net members can use one of the following screening tools, as appropriate to the member's plan:

- Patient Health Questionnaire-2 (PHQ-2).
- Patient Health Questionnaire-9 (PHQ-9).
- Edinburgh Postnatal Depression Scale.

You can refer members with a positive screen to Health Net's Case Management Department for further assistance with the member's mental health needs.

COMPREHENSIVE RISK ASSESSMENT AND INDIVIDUALIZED CARE PLAN

CPSP providers should complete a comprehensive risk assessment and individualized care plan (ICP) if the obstetrical care provider is not providing the full scope of CPSP support services.

AGREEMENTS WITH CPSP PROVIDERS

Health Net participating providers who are not CPSP-certified by the CDPH are required to enter into agreements with CDPH-certified CPSP providers to ensure that all pregnant women have access to care in accordance with
DHCS requirements.

REQUIRED SERVICES

Required services include:

- Client orientation.
- Obstetrical services.
- Nutrition, psychosocial and health education support services initial assessments.
- Formal reassessments at each subsequent trimester and in the postpartum period.
- Development of ICPs that include planned actions as indicated by the assessments and objectives for each of the four categories, with revision at least each subsequent trimester and postpartum.
- Case coordination.
- Vitamin and mineral supplementation.
- Referral to WIC.

- Provision of, or referral for, dental, genetic, family planning, and preventive, well-child screening care exams and services.

CDPH-certified CPSP providers who contract to provide CPSP support services for non-certified providers are responsible for providing:

- Support services and assessments.
- ICPs.
- Reassessments.
- Interventions and case coordination information to pregnant members enrolled in CPSP upon referral from the identified obstetric provider.

The division of responsibilities between obstetric care providers and CDPH-certified CPSP providers to render CPSP support services are outlined below. Providers in a PPG should contact their PPG administrator for CPSP support services resources.

OBSTETRIC PROVIDER RESPONSIBILITIES

- Provide all obstetrical care, including antepartum, intrapartum and postpartum care.
- Prescribe prenatal vitamins and indicated medications.
- Refer all pregnant Medi-Cal members to CPSP support services providers.
- Provide a copy of all antepartum exams, labor and delivery experience, and postpartum exam to a CPSP support services provider to be included in the CPSP chart.
- Include copies of all assessments, reassessments and interventions by a CPSP support services provider in the medical chart.

RESPONSIBILITIES OF CPSP SUPPORT SERVICES PROVIDER

- Provide support services assessment, an ICP, reassessments, interventions, and case coordination to pregnant members enrolled in CPSP pursuant to a referral.
- Bill for all CPSP services, including the case coordination bonus as indicated in the provider's contract.
- Provide a copy of assessments, reassessments and intervention documentation to the obstetric provider for inclusion in the obstetric medical record each trimester or more frequently if needed.
- Include copies of obstetric exams, labor and delivery experience, and the postpartum exam in the CPSP chart as received from the obstetric provider.

The ICP must comply with the requirements described in the previous discussion of the Comprehensive Risk Assessment and Individualized Care Plan.

The Health Net Medi-Cal Health Care Services Department is available to coordinate care with other case management agencies to ensure that services are available to the member and to avoid duplication.

The obstetric care provider must complete the Perinatal Notification and Assessment Report, which was developed for reporting risk assessment data. Once completed, the form must be faxed to the Health Net Medi-Cal Health Care Services Department.

MONITORING AND OVERSIGHT

Health Net assesses and tracks participating providers' ability to deliver CPSP services required by Medi-Cal. Health Net monitors compliance and provision of obstetrical services according to the ACOG *Guidelines for Prenatal and Perinatal Care*.

BILLING

Individual participating providers (no PPG affiliation) who are not certified by the CDPH for CPSP are reimbursed for maternity services with a global professional fee, which includes all professional services normally provided for routine perinatal care. CPSP providers should bill each service separately, using the DHCS-designated Z codes.

Social Determinants of Health

Capturing social determinants of health (SDOH) data is a critical step in evaluating population health. This is done by reviewing member traits, health, social and risk needs. The emphasis is to improve health equity and identify health disparities and their root causes. This data will also aid in planning and coordinating care as well as providing personalized care to your patients.

HOW TO SUBMIT SDOH DATA

Refer to the 18 Department of Health Care Services (DHCS) priority SDOH codes below when documenting SDOH as they relate to your patient. Submit these on claims or encounters. The codes are based on the ICD-10-CM.

DHCS Priority SDOH Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z59.0	Homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance and death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Special Supplemental Nutrition Program for WIC

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a 100% federally funded program that provides nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low-to-moderate income (up to 185% of the federal poverty level) women and children up to age 5. The purpose of WIC is to prevent infant mortality, low birth weight and other poor birth outcomes, and to improve the nutrition and health of participants. PCPs inform eligible members of the availability of WIC services during office visits.

WIC PROGRAM SERVICES

WIC participants receive a packet of food vouchers each month that they can redeem at a local retail market of their choice for supplemental foods such as milk, eggs, cheese, cereal and juice, which provide nutrients essential for healthy pregnancies and children. WIC participants attend monthly nutrition and health education classes and receive nutrition counseling from registered dietitians and nutrition program assistants. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breastfeeding.

WIC does not provide medical nutrition therapy. This is the PCP's responsibility. WIC does, however, provide nutrition counseling consistent with the physician's plan of care.

WIC does not provide medically necessary or medically indicated formulas to participants enrolled in Medi-Cal managed care plans. Such formulas, which are referred to as therapeutic formulas by WIC, are a benefit under the Medi-Cal managed care program. When prescribing a medically necessary/therapeutic formula, providers must request authorization from their PPG or the plan.

IDENTIFYING ELIGIBLE BENEFICIARIES

Medi-Cal members are eligible for WIC services if they are:

- Pregnant.
- Breastfeeding (up to one year after childbirth).
- Non-breastfeeding women up to six months after termination of pregnancy (live birth, still birth, fetal death, or miscarriage).
- Children under age 5.
- Determined by a WIC nutritionist to be at nutritional risk.

REFERRALS TO WIC

PCPs are responsible for referring eligible members to WIC programs, providing required documentation with each referral, and coordinating follow-up care. On request, Health Net assists in coordinating the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals for WIC services must be made on one of the following:

- WIC Pediatric Referral form (PM 247A).
- WIC Referral for Pregnant Woman form (PM 247).
- WIC Referral for Postpartum and Breastfeeding Women form (PM 247).
- Completed photocopy of page 7 of the CPSP Prenatal Combined Assessment and Reassessment Tool.
- Physician prescription pad.

WIC requires hemoglobin or hematocrit test values at initial enrollment and when participants are recertified.

These are used in assessing eligibility for WIC program benefits.

Health Net's Public Programs Department negotiates a memorandum of understanding with local WIC agencies to facilitate coordination and communication between Health Net and the agency. Health Net's Public Programs Department also works with WIC agency liaisons to handle conflicts that might arise between the WIC agency and Health Net or a participating provider.

Chapter 5 – Sensitive and Self-Referral Services

This chapter covers those public health programs and services that have been designated by the California Department of Health Care Services (DHCS) as sensitive and self-referral services. Additional information regarding timely access to these services is provided on page 43. A summary and the Medi-Cal Referral Variations Matrix is included on page 76.

Sensitive Services

Sensitive services are those services that have been identified as requiring confidentiality by law or contract. Sensitive services are:

- Family planning services.
- HIV counseling and testing.
- Pregnancy testing, including pregnancy termination.
- Diagnosis and treatment for sexually transmitted infections (STIs).

Additionally, some carve-out public programs are also sensitive services. The following sensitive services are covered in Chapter 6:

- Alcohol and drug treatment services.
- Mental health.

Confidential Information

Protected health information (PHI) is considered confidential and encompasses any individually identifiable health information, including demographic information collected from a member, which is created or received by Health Net and relates to the past, present or future physical, mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member, or there is a reasonable basis to believe the information may be used to identify the member. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written member authorization. Participating providers must maintain the confidentiality of member information pertaining to the member's access to these services.

Self-Referral Services

DHCS allows Medi-Cal beneficiaries the option of self-referring for certain services without prior authorization. Members may receive these services from any qualified in-plan provider, and some of these services may be provided by qualified out-of-network providers. Health Net or the participating physician group (PPG) is responsible for payment to out-of-network providers for these services.

Minor's Consent for Services

Medi-Cal members under age 18 may access and obtain minor consent services without parental consent and without prior authorization of coverage. Minor consent services are related to covered services of a sensitive nature as shown in the table starting on the next page, and are categorized by age as follows:

	Minor may consent if age 12 and over	Minor may consent if under age 12
Family planning (prevention and treatment of pregnancy, except sterilization)	Yes	Yes

Abortion* (termination of pregnancy)	Yes	Yes
Sexual assault, including rape	Yes	Yes
Infectious, contagious, communicable diseases (diagnosis and treatment)	Yes	No
Sexually transmitted diseases (prevention, diagnosis and treatment)	Yes	No
AIDS/HIV (prevention, diagnosis and treatment)	Yes	No
Drug and alcohol abuse	Yes	No
Outpatient mental health	Yes	No

Members may access most services from any qualified provider, in- or out-of-network, except as follows:

- Obstetrical care for pregnancy – Must be accessed through an in-network provider (pregnancy testing is considered to be a family planning service and may be obtained from any qualified provider in- or out-of-network).
- Drug and alcohol treatment – Members are entitled to confidential, timely referral to the county drug and alcohol program; refer to the Public Programs topic for additional information.
  - Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill (AB) 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent or guardian consent is necessary for maintenance narcotic replacement therapy.
- Mental health care – Refer to the Public Programs topic for additional information. Members ages 12 or older can consent to mental health treatment or counseling without needing to meet specific conditions. Additionally, mental health professionals can now consult with minors before involving their parents or guardians if they believe it's inappropriate to do so.

MEDI-CAL REFERRAL SERVICE VARIATIONS

	Mandatory referral[1]	Self referral[2]	Out-of-network provider[3]
Preventive and screening for newborns[4]	X		No
CPSP services	X		No
Dental – annually for children over age 3	X	X	N/A
Elective pregnancy termination		X	Yes
Family planning (including pregnancy testing)		X	Yes
HIV testing and counseling	X (w/pregnancy)	X	Yes
Immunizations		X	Local health department only
OB care		X	No
STIs		X	Yes
WIC	X		N/A

*American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (1997)

[1]Those program-mandated services to which a PCP must refer the member.

[2]Those services that may be accessed by the member at any time without a referral or authorization.

[3]Members may obtain services from a nonparticipating provider as indicated.

[4]Obstetric care practitioners caring for a newborn must inform the mother of required preventive and screening services and refer the member to a well-child screening service practitioner.

Family Planning Services

Medi-Cal members have the right to access family planning services without referral or prior authorization from any qualified Medi-Cal enrolled participating or nonparticipating family planning provider in- or out-of-network. A qualified participating or nonparticipating provider includes a member's PCP, other participating or nonparticipating provider, OB/GYN, nurse midwives, nurse practitioners (NPs), physician assistants (PAs), federally qualified health centers (FQHCs), Indian Health Clinics (IHCs), Rural Health Centers (RHCs), and county family planning providers. Providers may not restrict a member's access to family planning services. Providers who do not comply are subject to administrative review or disciplinary action.

Capitated PPGs are responsible for payment of claims to all qualified family planning providers for appropriate billable services covered by the DHCS Medi-Cal fee-for-service (FFS) program, including office visits, laboratory tests, and Medi-Cal-approved contraceptive medications, devices and supplies. Refer any problems involving claims payment responsibility to a provider network management representative.

AVAILABLE SERVICES

The following family planning services are available for all members of childbearing age:

- Health education and counseling necessary to make informed choices and understand contraceptive methods.
- Limited history and physical examination.
- Laboratory tests, if medically indicated, to assist with decision-making for contraceptive methods (except cervical cancer screening, such as a Pap test, provided by a nonparticipating provider where the plan has previously covered a cervical cancer screening performed by a participating provider in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines).
- Diagnosis and treatment of STIs.
- Screening, testing and counseling of individuals at risk for HIV infection.
- Most methods of sterilization (the member must be at least age 21 at the time consent is obtained), including:
  - tubal ligation
  - vasectomy
- The same methods of birth control as covered by DHCS for the Medi-Cal Fee-for-Service (FFS) program, devices and supplies (including Depo-Provera® and Lunelle™). Members may receive up to a 12-month supply dispensed at one time for U.S. Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives, such as 13 vaginal rings, 52 patches and 18 cycles of oral contraceptives.
  - Oral contraceptives are covered when dispensed from an onsite clinic and billed by any qualified provider. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a Medi-Cal enrollee as specified in Title 22, California Code of Regulations, Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, nurse practitioner, and pharmacist are authorized to dispense medications. When furnished by a pharmacist self-administered hormonal contraceptives must be dispensed in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Pursuant to the California Business and Professions Code (B&P Code), Section 2725.2, if contraceptives are dispensed by a registered nurse (RN), the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with evaluation and management (E&M) procedure codes 99201, 99211 or 99212 with modifier TD (used for behavioral health RN) as directed in the DHCS Medi-Cal Provider Manual.
- Office-administered follow-up treatment of complications associated with contraceptive methods issued by the family planning provider (limited to two outpatient visits without prior authorization,

when provided by a nonparticipating provider).

- Outpatient office visits to manage minor issues associated with hormonal methods of birth control, not limited to two visits; prior authorization is not required.
- Pregnancy testing and full options counseling when performed by trained staff under the supervision of a licensed physician.

MEMBER EDUCATION

Health Net provides members the following information on family planning services:

- The member's option to receive family planning services from any qualified participating provider (in- or out-of-network), without referral or prior authorization of coverage.
- A complete list of the services offered and descriptions of limitations on the family planning services members may seek from nonparticipating providers.
- The member's right to timely services.
- Notification that members must provide informed consent for sterilization.
- That confidentiality of medical information and personal data of all members is maintained through strict adherence to applicable state and federal requirements.
- The member's right to confidentiality when receiving socially sensitive services, including the availability of services for minors without parental consent.
- The positive effect of coordinated care on health outcomes.

PROVIDER RESPONSIBILITY FOR OBTAINING INFORMED CONSENT

Providers must inform members before they undergo sterilization procedures, and providers must obtain the member's consent. Providers must provide members to be sterilized with the DHCS-published brochure on sterilization before obtaining consent. The following are the only sterilization information booklets approved by DHCS:

- Permanent Birth Control for Women.
- Método Anticonceptivo Permanente Femenino.
- Permanent Birth Control for Men.
- Método Anticonceptivo Permanente Masculino.

Providers can log in to the DHCS website to download and print the booklets. The DHCS Consent Form PM 330 is the only form approved by DHCS for certification of informed consent. Providers must fully and correctly complete the DHCS Consent Form PM 330. The form must include the name of the provider or clinic furnishing the procedure information and the provider or clinic performing the procedure (lines 1 and 5 on the PM 330). These lines on the form may be pre-stamped or typed. The name of the procedure must be included on lines 2, 6, 13, and 20 and must be consistent throughout the form and match the name of the procedure on the claim submission. These lines may also be pre-stamped or typed.

Providers must cross out the alternative final paragraph on the form that is not used. If the minimum waiting period of 30 days has been met, providers must cross out paragraph 2. If the minimum waiting period has not been met, providers must cross out paragraph 1.

The PM 330 must be signed and dated by the member to be sterilized, the interpreter (if one is used in the consent process), the person who secured the consent (for example, physician or intake nurse), and the provider performing the sterilization. Providers must note in the member's medical record that the provider gave the member the DHCS-published booklet about sterilization and retain a copy of the signed consent form.

COORDINATION WITH OUT-OF-NETWORK PROVIDERS

Health Net encourages the PCP to coordinate care with nonparticipating providers to avoid duplication of services. If the PCP previously provided the service the nonparticipating provider is now providing, the nonparticipating provider is not paid (unless he or she has documented attempts to contact the member's PCP for medical information).

When a member requests medical records to be forwarded to a nonparticipating provider, it is the PCP's responsibility to comply. The PCP must obtain a completed, signed consent form from the member for records to be transferred to a nonparticipating provider.

If the member needs medically necessary follow-up care, the nonparticipating provider must obtain signed consent from the member to the member's PCP. Health Net's Health Care Services staff are available to assist nonparticipating providers if any concerns arise about timely provision of services and referrals arise.

PROBLEM RESOLUTION

Any conflicts concerning provision of family planning services should be referred to Health Net's Public Programs Department for resolution. During any problem periods, a Health Net care manager and the PCP or specialty provider continues to coordinate the member's care.

HIV Testing and Counseling

Participating and non-participating providers may provide confidential HIV testing, counseling and follow-up services to Medi-Cal members, without authorization. Providers must provide information about HIV testing, treatment options and additional testing needed, and advise members of their rights to decline testing. If a member declines HIV testing, the provider must document this information in their medical record.

When a member requests confidential HIV testing, counseling or follow-up services, the provider or staff person with authority and license to do so, must administer pre-test counseling services, obtain a complete history and physical (if indicated), and order the requisite lab work. The provider must follow the Centers for Disease Control and Prevention (CDC) guidelines for pre- and post-testing counseling.

Members may also obtain confidential or anonymous HIV testing and counseling services from the local health department (LHD), a community-based organization testing site or nonparticipating family planning provider. The member's PCP must perform follow-up services. Members who are age 12 years and older may get HIV/AIDs preventive, testing and treatment services without parent's or guardian's permission.

MANDATORY OFFERING

Health Net PCPs are required to counsel and offer HIV testing to pregnant Medi-Cal members. Health Net recommends the use of the California Perinatal HIV Testing Project guidelines available on the California Department of Public Health (CDPH) website at www.cdph.ca.gov.

RELEASE OF CONFIDENTIAL PATIENT MEDICAL INFORMATION

The custodian of records is responsible for controlling the release of records related to HIV testing to any third party not involved in the member's care.

If a copy of the member's medical record is requested, the custodian of records must review the record and remove the confidential envelope containing the consent form or the HIV test results, along with any other portion of the record that contains documentation of the HIV test being ordered or the HIV test results (for example, history, physical, consultations, and progress notes). If the HIV test or HIV test results are mentioned anywhere in the medical record, the information is protected. If necessary, the custodian must explain that the protected portion of the record requires special written authorization from the member. The custodian of

records must not identify in any way that the record is confidential because of the HIV or AIDS test. It must state that it is a protected record under state law that requires special authorization from the member. After removing all confidential material, the record may be released to the requestor.

Pregnancy Services and Pregnancy Termination

Pregnancy services are covered on pages 70–73.

PREGNANCY TERMINATION

An abortion is classified as a sensitive service. Medi-Cal members may obtain an abortion from any qualified provider, in or out of plan, without obtaining a referral or prior authorization (unless the abortion is performed during an inpatient hospitalization). Members may also receive mifepristone (RU-486) in accordance with the Food and Drug Administration (FDA)-approved treatment regimen and other mandated requirements.

A Medi-Cal member seeking an abortion may self-refer or request a referral from her PCP. If asked for a referral, PCPs may direct members to an abortion provider within their PPG, but may not indicate in any manner that the member cannot seek services elsewhere. A qualified provider of abortion services is the member's PCP, an OB/GYN, certified nurse midwife, nurse practitioner, physician assistant, family planning clinic, or federally qualified health center (FQHC).

Sexually Transmitted Infections

Diagnosis and treatment of STIs are available to Health Net Medi-Cal members without prior authorization. Members may choose any qualified provider, in- or out-of-network, including LHDs and family planning clinics, for care of an STI episode without prior authorization. STI services include education, prevention, screening, counseling, diagnosis, and treatment.

Out-of-network services provided by LHDs and family planning providers are limited to the following:

- one office visit per disease episode for the purposes of:
  - (1) diagnosis and treatment of vaginal discharge and urethral discharge,
  - (2) those STIs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale; and
  - (3) evaluation and treatment of pelvic inflammatory disease.

Additional visits require prior authorization and may require that the member be referred back to his or her PCP for any additional medically necessary follow-up or treatment.

For community providers other than LHD and family planning providers, out-of-network services are limited to one office visit per disease episode (follow-up care must be obtained in-network).

PCP RESPONSIBILITIES

PCPs are responsible for primary treatment of STIs. The PCP may perform the service or refer members to LHD clinics, participating specialists, or, on request of the member, out-of-network providers.

PCPs are responsible for reporting incidences of STIs to the LHD within specific time frames. When reporting to the LHD, the following information must be included:

- Member demographics (name, age, address, home phone number, date of birth, gender, ethnicity, and marital status).
- Locating information (employer, work address and phone number).

- Disease information (diagnosed date of onset, symptoms, laboratory results, and prescribed medications).

PCPs shall screen for chlamydia in all sexually active women 24 years or younger and women 25 years or older who are at increased risk for infection, in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations. Follow up for positive results must be documented in the medical record.

If the member refuses to have the chlamydia screening performed, unsuccessful attempts and refusals to screen must be documented in the member's medical record by the PCP.

PCPs should document any preventive care and health education counseling provided at the time of a routine exam for all members with high-risk behaviors for STIs.

Access to STI services by minors, including confidentiality and monitoring of STI services, is a covered benefit.

NONPARTICIPATING PROVIDERS

Health Net requests that nonparticipating providers contact the Health Net Medi-Cal Member Services Department to verify eligibility and benefits and to obtain billing instructions for Medi-Cal members. The nonparticipating provider is given the name of the member's PCP to arrange for follow-up services.

Nonparticipating providers may also use either an EDS Point of Service (POS) device or the Affiliate Computer Services (ACS) by phone to confirm eligibility. If the nonparticipating provider contacts the PCP directly, the PCP is responsible for coordinating the member's care with the nonparticipating provider.

If the nonparticipating provider requests care management services, the request is forwarded to the Medical Management Department. The Medical Management Department arranges for any necessary follow-up care and coordinates with the member's PCP.

MEMBER EDUCATION

Health Net's member education on STIs includes disease-specific material, the right to out-of-network treatment, health assessment for risk factors and how to obtain preventive services. Members are advised of these services in the *EOC*. The Health Education System sends STI health education information to providers on request.

REIMBURSEMENT

Participating Providers

Participating providers must bill Health Net, or the capitated PPG, in accordance with their *Provider Participation Agreements (PPAs)*.

Individually participating providers who provide STI services are reimbursed at the allowable Medi-Cal FFS rate determined by DHCS if a specific rate has not been included in the *PPA*.

Denials of STI services (for example, for patient ineligibility under the Medi-Cal program) are sent to the provider of service to protect the member's privacy.

The Plan Medi-Cal providers may submit appeals to the Provider Disputes Department for any unresolved claims issue. The procedure is outlined for providers in the Plan's Medi-Cal Provider Manual.

Members may submit appeals to the Plan's Medi-Cal Member Appeals and Grievance Department for any unresolved claims issue. The procedure is outlined for Members in the Evidence of Coverage document. Any questions or issues should be referred to the Plan's Medi-Cal Member Services Department.

Chapter 6 – Public Health Carve-Out Services

Public health programs provide a wide variety of services to Medi-Cal beneficiaries at the county, state and federal levels. Physicians, public health programs and Health Net coordinate their efforts to assist Medi-Cal beneficiaries in receiving the full scope of available benefits and services.

Carve outs are those services and programs available to members that are administered and paid by sources other than Health Net. Members using these services continue to be enrolled with Health Net.

This chapter details the carve-out services available to members, eligibility requirements, referral and authorization processes, and care coordination requirements. For clarification, the Carve Out and Waiver Programs matrix, included on page 87, lists the public health programs available to Medi-Cal members and indicates the type of program; status of member enrollment when these services are used; and payer, referral and authorization sources (waiver programs are covered in Chapter 7).

Referral Notification

Providers must report Medi-Cal members they refer to public health programs, excluding those referred for sensitive services. Notification to Medical Management may be made via email or fax and must include the following information:

- Member name.
- Member identification (ID) number.
- Provider name.
- Date and type of referral.
- For California Children's Services (CCS), include diagnosis.

Problem Resolution

Unless otherwise noted, disputes or problems that arise between the public health programs described in this chapter and Health Net or the primary care physician (PCP) are handled by Health Net's Public Programs Department. During any such period, a Health Net care manager and the PCP or specialty provider continue to coordinate the member's care.

CARVE OUTS AND WAIVERS

Note: The PCP maintains responsibility for all primary care services regardless of members' enrollment in any public health program.

	Excluded under HN contract	Waiver[1]	Carve out[2]	Disenrolled	Enrolled	Referral source	Authorizing source	Payer source
Medi-Cal waiver	X	X		X (patient choice)		PCP, Specialist	Local Medi-Cal Waiver Program	Local Medi-Cal Waiver Program
Alcohol and drug treatment	X		X		X	PCP	County Alcohol and other Drug Treatment (AOD) Programs	AOD
CCS	X		X		X	PCP, Specialist	CCS	CCS
Dental	X		X		X	PCP, Self	TAR Local	MCFFS
Direct Observation Therapy (DOT)	X		X		X	PCP	TAR Local	MCFFS
Home & Comm. Based waiver – Department of Developmental Services (DDS)	X	X			X	PCP	Regional Center	Regional Center
Home & Comm. Based waiver – IHO (IHMC, SNF, Model)	X		X	X		PCP	IHO Sacramento	IHO Sacramento
Home & Comm. Based waiver – DOA (MSSP)	X		X		X	PCP, Specialist, Self	Dept. of Aging Local Contractor	Dept. of Aging Local Contractor
LEA	X		X		X	Self, PCP	LEA	LEA
Intermediate Care Facility	X		X	X		Regional Center	TAR, Regional Center	MCFFS
Specialty mental health only	X		X		X	PCP, Self	County Mental Health Plan	County Mental Health Plan
Organ transplant – child (CCS)	X		X		X	PCP, Specialist	CCS	CCS
Regional center coord. (Early Start)	X		X		X	PCP, Specialist	DDS	DDS
Refugee health	X		X	N/A	N/A	PCP, Other	LHD	LHD

[1]Programs in which payer source is other than Health Net and the member is usually disenrolled (exceptions: HCBS waivers under DDS and MSSP).

[2]Programs in which the payer is other than Health Net and the member is not disenrolled.

Alcohol and Drug Treatment Services

Alcohol and drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. These services are administered by counties and overseen by the state of California.

Health Net, its affiliated health plans and subcontracting providers are available to coordinate referrals for members requiring substance abuse treatment and services. Members receiving services under this program remain enrolled in Health Net. Participating PCPs are responsible for maintaining continuity of care for the member. Additionally, participating PCPs must maintain documentation of Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services. Member medical records must include the following:

- The service provided (e.g., screen and brief intervention).
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). and
- If and where a referral to an alcohol use disorder (or substance use disorders) program was made.

The alcohol and drug treatment services covered by the Drug Medi-Cal (D/MC) program include:

- Outpatient heroin detoxification services.
- Outpatient methadone maintenance services.
- Outpatient drug-free treatment services.
- Day care habilitative services.
- Perinatal residential substance abuse services.

REFERRAL DOCUMENTATION

Participating providers are responsible for performing all preliminary testing and procedures necessary to develop a diagnosis. Referrals to D/MC or fee-for-service Medi-Cal (FFS/MC) programs must include the appropriate medical records supporting the diagnosis and additional documentation. The referring provider must obtain a signed release from the member prior to making the referral.

The final decision on the acceptance of a member for FFS/MC or D/MC services (authorization of the referral) rests solely with the county alcohol and drug program.

MEDICATION ASSISTED TREATMENT

Medications for addiction treatment also known as medication-assisted treatment (MAT) are covered when delivered in primary care offices, emergency departments, inpatient hospitals, and other contracted medical settings.

CONTINUITY OF CARE

Providers are responsible for providing services in a manner that ensures coordinated, continuous care to all members needing alcohol and drug treatment services, including timely referral.

On receipt of a specific written request from the member, the PCP must transfer requested summaries of the member's records to the substance abuse practitioner or program and to any organization where future care will be

rendered. Any transfer of member medical records and other information must be done in a manner consistent with Health Net's confidentiality standards.

A member receiving services under the Alcohol and Drug Treatment Program remains enrolled with Health Net. The PCP and Medical Management staff retains responsibility for maintaining continuity of care for the member. The PCP is responsible for coordinating with the Alcohol and Drug Treatment Program case managers and the Medical Management staff. The PCP monitors the member to ensure that follow-up care is provided when necessary.

California Children's Services

The California Children's Services (CCS) program provides specialized medical care, rehabilitation services and case management to children with medical or surgical conditions who meet program eligibility requirements. CCS services are delivered by paneled providers and approved tertiary care medical centers in the local communities that meet CCS program requirements.

CCS services are carved out under the Medi-Cal managed care program, but the member remains enrolled with Health Net or its subcontracting plan for the purpose of receiving primary care and services unrelated to the CCS condition. The responsibility for paying for treatment services for the CCS-eligible condition of the child enrolled in managed care rests with the CCS program rather than the health plan.

It is essential that physicians identify children with CCS-eligible conditions and arrange for their timely referral to the county CCS program. The PCP provides a complete baseline health assessment and diagnostic evaluations sufficient to ascertain the evidence or suspicion of a CCS-eligible condition. The PCP remains responsible for the complete health care of the member until CCS program eligibility is determined.

Once CCS eligibility has been established, the CCS program assumes case management responsibilities, including prior authorization of, and payment for, all services related to the CCS condition. The PCP remains responsible for providing primary care services to the member, including coordination with CCS and specialists to ensure continuity of care.

CCS does not pay for services provided before the date of referral, even though the child may have a CCS-eligible condition, except for children with full-scope Medi-Cal and emergency services or services rendered after hours. Referrals for emergency or after-hours care must be made to the county CCS program on the next business day and must include documentation substantiating necessity for emergency or urgent care.

CCS Program Components

Diagnosis and Treatment Program

The diagnosis and treatment program provides medically necessary care and case management for infants, children and adolescents meeting program eligibility requirements. This care is delivered by CCS-paneled providers who meet program standards in tertiary care medical centers and in local communities.

Medical Therapy Program

Medical Therapy Program (MTP) services are delivered by local CCS programs to children with cerebral palsy and other neuromuscular conditions.

MTP provides medically necessary physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services to children who are medically eligible for the program. A medical therapy unit (MTU) team performs examinations and prescribes PT, OT, durable medical equipment (DME), and any other necessary medical interventions required to treat the child's CCS-eligible diagnosis. MTUs are located at selected public schools as part of an interagency agreement with the California Department of Education.

High-Risk Infant Follow-Up Program

The High-Risk Infant Follow-Up (HRIF) program provides outpatient services to infants who meet the CCS medical eligibility criteria for a CCS-approved neonatal intensive care unit (NICU), or had a CCS-eligible medical condition during their stay in a CCS-approved NICU, even if they were never CCS clients during their NICU stay. This also includes newborns who are at risk of developing a CCS-eligible medical condition. These services include comprehensive history and physical examination, including neurological and developmental assessment, ophthalmological and audiological evaluations, and family psychosocial and home assessments, including coordination of HRIF services during the first three years of life.

Orthodontic Screening Program

Orthodontic services are a benefit of the CCS program for children with severe malocclusion if evaluated by CCS-paneled orthodontists and determined to be medically eligible for orthodontic services as defined by CCS.

Newborn and Infant Hearing Screening Program

The Newborn and Infant Hearing Screening program offers hearing screening to all infants delivered in CCS-approved hospitals and CCS-approved neonatal intensive care units (NICUs) prior to the infant's discharge. Infants identified through the Newborn Hearing Screening program that need diagnostic or treatment services are referred to appropriate health care and support services. Infants eligible for the CCS program are referred to a CCS-approved Communication Disorders Center for audiological services.

CCS PROGRAM ELIGIBILITY

The CCS program is open to members who:

- Are under age 21.
- Have a physical limitation or disease that is covered by CCS.
- Are residents of California and apply in their county of residence.
- Have a family income of either:
  - Less than $40,000 reported as adjusted gross income on the state tax form, or
  - More than $40,000 reported as adjusted gross income on the state tax form, but out-of-pocket costs of care for the CCS-eligible condition are expected to exceed 20% of the family's adjusted gross income.

Family income is not a factor for children who:

- Need diagnostic services to confirm a CCS eligible medical condition.
- Were adopted with a known CCS eligible medical condition.
- Are applying only for services through the Medical Therapy Program.
- Have Medi-Cal full scope, no share of cost.

CCS-ELIGIBLE CONDITIONS

The following is a categorical list excerpted from the CCS Medical Eligibility Regulations identifying the general types of conditions and some examples that may be medically eligible for the CCS program (refer to the Medi-Cal provider operations manuals for a more detailed summary of the types and conditions):

- Infectious diseases (HIV when confirmed by laboratory tests, osteomyelitis).
- Neoplasms (cancers, tumors).
- Endocrine, nutritional and metabolic diseases and immune disorders (thyroid problems, diabetes, PKU).
- Diseases of blood and blood-forming organs (hemophilia, sickle cell problems).
- Mental disorders and intellectual disability (conditions of this nature are not eligible except when the

disorder is associated with or complicates an existing CCS-eligible condition).

- Diseases of the nervous system (cerebral palsy, multiple sclerosis).
- Diseases of the eye (glaucoma, cataracts).
- Diseases of the ear and mastoid process (hearing loss, mastoiditis, cholesteatoma).
- Diseases of the circulatory system (tetralogy of fallot, pulmonary atresia, coactation of aorta).
- Diseases of the respiratory system (cystic fibrosis, respiratory failure).
- Diseases of the digestive system (diseases of the liver, chronic intestinal failure).
- Diseases of the genitourinary system (chronic nephrosis, acute kidney failure, chronic renal disease).
- Diseases of the skin and subcutaneous tissues (pemphigus, epidermolysis bullosa).
- Diseases of the musculoskeletal system and connective tissue (rheumatoid arthritis, lupus erythematosus).
- Congenital anomalies (spina bifida, hydrocephalus, cleft palate and cleft lip).
- Accidents, poisonings, violence, and immunization reactions (ORIF, fractures involving joints/growth plates).
- Pediatric intensive care.

Refer to Title 22, California Code of Regulations (CCR) Section 41515.1, which states medical eligibility for the CCS program, as specified in Sections 41515.2 through 41518.9, is determined by the CCS program medical consultant or designee through the review of medical records that document the applicant's medical history, results of a physical examination by a physician, laboratory test results, radiologic findings, or other tests or examinations that support the diagnosis of the eligible condition.

REFERRAL TO CCS

The CCS program accepts referrals for eligibility determination from any source (for example, PCP, specialist, facility, medical group, teacher or parents). A referral may be sent on a CCS/GHPP Service Authorization Request (SAR) form including all of the following information:

- Member's name.
- Member's date of birth.
- Name, address and phone number of the parent or legal guardian.
- Medical condition.
- Description of services/procedures being requested.
- Name of CCS-paneled provider and phone number.
- Name, address and phone number of the referral source.

PCPs, specialists and participating physician group (PPG) staff must refer potentially eligible children to the local CCS program within 24 hours of identification and inform the parent or legal guardian of the referral to the CCS program. Hospitals and providers must refer potentially eligible children to CCS within 24 hours of inpatient admission and inform the parent or legal guardian of the referral to the CCS program.

Referrals to CCS must include:

- Completed CCS SAR form with required information.
- Medical history with sufficient medical information to ascertain the evidence or suspicion of a CCS-eligible condition.
- Recent medical records pertaining to a medically eligible diagnosis or condition.
- Description of services being requested.

- Name of CCS-paneled provider who will provide the requested services (if known).
- Name and phone number of the referral source.
- Completed CCS Application for Service form (if available at the physician's office at the time of referral).

Providers referring a member that has an existing case with CCS should make a new referral using the Established CCS-GHPP Client SAR (PDF). If the member has a closed case, providers should make a new referral using the New Referral CCS/GHPP Client Service Authorization Request (SAR) (ca.gov)

The following are examples of the type of medical documentation that should be included with the CCS referral for some various diagnoses:

- Cerebral palsy – Detailed medical reports documenting the findings from a complete physical and neurological exam.
- HIV infection – Laboratory test results.
- Lead poisoning – Documentation confirming a blood level of 20 micrograms per deciliter or above.
- Scoliosis – X-ray reports showing a curvature of the spine greater than 20 degrees.

On receipt of a referral, the county CCS program sends a CCS program application and service agreement to the family.

CCS APPLICATION AND SERVICE AGREEMENT FORM

A signed Application to Determine CCS Program Eligibility on file with CCS provides a legal right to appeal if services are denied by the CCS program. Upon receipt of a completed application, the CCS program performs the eligibility determination.

CCS and Health Net strongly recommend that the CCS application and service agreement be completed to ensure that the member receives CCS program benefits. If the application is on file with CCS, the member may continue to receive services through CCS even if the member loses plan eligibility.

CCS PROGRAM AGREEMENT

The CCS program agreement is a consent form that indicates the family's willingness to abide by CCS program policies and procedures and offers recipients the full range of CCS program benefits.

REQUEST FOR SERVICES

The CCS program reviews the request for services and determines medical necessity. All services, except for emergency services and after-hour services, require prior authorization. If treatment of the CCS-eligible condition or for an associated complication is found to be medically necessary, the CCS program issues an authorization.

CCS SERVICE AUTHORIZATION REQUEST

CCS sends an authorization to the CCS-paneled provider indicating that the provider may deliver the services approved for treatment of the CCS-eligible condition. The provider is reimbursed by the state at an FFS rate. A separate service authorization request (SAR) New Referral CCS/GHPP Client Service Authorization Request (SAR) (ca.gov), Established CCS/GHPP Client Service Authorization Request (SAR) (ca.gov) must be obtained by the hospital and provider for each hospitalization.

TRACKING AND COORDINATION OF CARE

Participating providers are required to develop and implement a procedure for tracking CCS program referrals and submit a monthly report to the Health Net Delegation Oversight Department. Health Net is available to work with participating providers and care managers to facilitate referrals to CCS and continuity of care as needed.

PUBLIC PROGRAMS COORDINATION

On an annual basis, except when a member changes their PCP or clinic assignment, Health Net automatically generates a letter notifying their PCP that the member received services from the CCS program.

County Mental Health Plan

Services available under the Medi-Cal specialty mental health program are excluded from Health Net's coverage responsibilities. Health Net's PCPs provide outpatient mental health services within the scope of their practice and coordinate referrals for members requiring specialty or inpatient mental health services.

Members who need these services are referred for treatment to the county mental health plans (CMHPs). Each county is required by law to provide access to specialty mental health services for Medi-Cal members, which are overseen by the California Department of Mental Health.

SPECIALTY MENTAL HEALTH SERVICES

Specialty mental health services covered by the county mental health plans (CMHPs) include:

- Outpatient services:
  - Mental health services, including assessments, plan development, therapy and rehabilitation.
  - Medication support.
  - Day treatment services and day rehabilitation.
  - Crisis intervention and stabilization.
  - Targeted case management.
  - Therapeutic behavior services.
- Residential services:
  - Adult residential treatment services.
  - Crisis residential treatment services.
- Inpatient services:
  - Acute psychiatric inpatient hospital services.
  - Psychiatric inpatient hospital professional services.
  - Psychiatric health facility services.

Medi-Cal members receiving services through a CMHP remain enrolled in Health Net. The PCP retains responsibility for primary care management. This includes coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications, notwithstanding whether the member receives care through the CMHP.

PCP RESPONSIBILITIES

PCPs provide outpatient mental health services within the scope of their practice. The PCP is responsible for identifying and treating, or making a specialty medical referral for, the member's general medical conditions that cause or exacerbate psychological symptoms.

If members require mental health services for mild to moderate conditions, PCPs may refer members to Health Net for assessment and referral to a mental health provider. PCPs must continue to:

- Make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition that resulted in a referral.
- Ensure the appropriate documentation is included in the member's medical record.
- Respond to requests to coordinate non-specialty mental health conditions and services with specialists.

Examples of mental health services generally considered appropriate to be provided by the PCP are:

- Complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, overeating, headaches, pains, digestive problems, altered sleep problems and acquired sexual problems).
- Diagnosis of physical disorders with behavioral manifestation.
- Maintenance medication management after stabilization by a psychiatrist or, if longer-term psychotherapy continues, with a non-physician therapist.
- Diagnosis and case management of child, elder and dependent adult abuse and domestic violence victims.
- Coordination of psychological assessments to rule out:
  - General medical conditions as a cause of psychological symptoms.
  - Mental or substance-related disorders caused by a general medical condition.

REFERRAL PROCESS

The need for referral for specialty mental health services is determined by the PCP's evaluation of the member's medical history, psychosocial history, current state of health, and any request for such services from either the member or the member's family. Once the determination has been made to refer the member for mental health services, PCPs may do one of the following based on the member's level of mental health impairment:

- For members with mild to moderate impairment, refer to Health Net at 844-966-0298 for assistance.
- For Molina members with mild to moderate impairment, refer to Behavioral Health Services at 888-665-4621 for assistance.
- For all Medi-Cal members with a severe level of impairment, refer to the County Mental Health Plan (CMHP) for specialty mental health services (SMHS).

Members may also self-refer to behavioral health services by calling the member services phone number listed on their identification card (ID).

HEALTH NET RESPONSIBILITIES

Health Net is responsible to:

- Cover all psychotherapeutic medications prescribed by participating PCPs and nonparticipating psychiatrists. Some medications for psychotic disorders and schizophrenia are covered under the Medi-Cal FFS program. Refer to the Medi-Cal Provider Library for a list of excluded psychotherapeutic medications.
- Monitor the availability of coordination of care services when indicated and requested by the PCP or mental health care provider.
- Monitor appropriate referral of members by PCPs through audits (specific services may be considered Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens supplemental services for members under age 21).
- Provide medically necessary emergency room (ER) professional services and medical transportation services for emergency medical conditions. This includes facility charges for ER visits that do not result in a psychiatric admission and all laboratory and radiology services necessary for the diagnosis, monitoring or treatment of the member's mental health condition.

Transportation for non-emergent conditions is not covered unless prior authorized. ER services for non-emergent medical conditions, services after stabilization or an emergency medical condition require authorization.

CONTINUITY OF CARE

PCPs should provide services and referrals in a manner that facilitates coordinated, continuous care to all members needing specialty mental health services.

Direct Observation Therapy for Tuberculosis

Direct observation therapy (DOT) services are offered by LHDs to monitor members with clinically active tuberculosis (TB) who have been identified by their PCP as at risk for potential noncompliance with the treatment regimen. DOT is a measure to ensure adherence to TB treatment for members at risk for noncompliance in taking medications or who are unable to follow the treatment regimen and to protect the public health. DOT is a technique requiring staff to assist members and to observe the ingestion of prescribed medications to treat TB. The purpose of DOT is to assure that the entire course of medication is taken in the correct dose, at the correct time and for the complete period of therapy.

DOT services are carved out under the Medi-Cal managed care program, but the member remains enrolled with Health Net for the purpose of receiving primary care and services unrelated to DOT. The responsibility for paying for DOT services for a member enrolled in managed care rests with the LHD rather than the health plan.

DOT REFERRALS TO LHDS

When a PCP identifies a member with TB who does not comply with the treatment regimen, the PCP must fax a copy of the DOT referral form to the LHD TB control officer. A copy of the referral form must also be faxed to the Medical Management Department.

The LHD must be notified when the PCP has reasonable grounds for believing that a member has ceased treatment, failed to keep an appointment, has adverse drug reactions, has relocated without transferring or discontinued care. The following members must be referred for DOT services:

- Members having multiple medication resistance (defined as resistance to Isoniazid® and Rifampin®).
- Members whose treatment has failed.
- Members who have a relapse after completing a regimen.
- Children.
- Adolescents.
- Noncompliant members.

Members with the following conditions should be considered for referral:

- Substance abuse.
- Major psychiatric, memory or cognitive disorders.
- Elderly.
- Homeless.
- Formerly incarcerated.
- Slow sputum conversion.
- Slow or questionable clinical adherence.
- Adverse reaction to TB medications.
- Poor understanding of their disease process and management.
- Language or cultural barriers.

FOLLOW-UP CARE

PCPs are required to coordinate with the LHD TB control officer and provide follow-up care to all members receiving DOT services. PCPs need to inform the LHD TB Control Program of any changes in the member's response to the treatment or drug therapy.

PCPs receive a periodic report from the LHD TB Control Program advising them of each member's treatment status. On completion of DOT services, the LHD TB Control Program faxes a copy of the member's medical record and final status report to the PCP.

The PCP then arranges an appointment to develop a follow-up treatment plan for the member. The PCP's staff calls or mails an appointment schedule slip to the member. If the member does not keep the appointment, a follow-up phone call or letter should be initiated. If there is no response, the PCP notifies the LHD TB Control program.

TRACKING AND COORDINATION OF CARE

Health Net's Medi-Cal medical directors confer, as needed, with the local TB Control Program to provide continuity of care and correct any identified deficiencies. They are available to care managers to assist in proper member management and member compliance issues.

When requested by the PCP, the Health Net Medi-Cal Medical Management Department is available to provide assistance with coordinating the member's care.

Early Start Program

The Early Start program provides family-centered early intervention services to infants and toddlers (from birth to 36 months) who have a developmental delay in one or more of the following areas: cognitive, physical and motor development, including vision and hearing; communication, social or emotional development or adaptive development; and those who have an established risk condition with a known etiology of causing a developmental delay/disability and those at high risk of having a substantial developmental disability due to a combination of biomedical risk factors, the presence of which is diagnosed by qualified clinicians recognized by, or part of, a multidisciplinary team including the parents. Health Net identifies children under age 3 who may be eligible to receive services from the California Department of Development Services (DDS) Early Start program and refers them accordingly.

PCP RESPONSIBILITIES

PCPs identify infants and toddlers (from birth to 36 months) who are at risk or suspected of having a developmental disability or delay through health screenings and assessments, including:

- Initial comprehensive physical evaluation for congenital abnormalities and/or treatable medical conditions.
- Developmental screening using EPSDT/Medi-Cal for Kids & Teens and/or American Academy of Pediatrics standards. PCP also arranges for the provision of medically necessary Behavioral Health Treatment (BHT) services even without a diagnosis of Autism Spectrum Disorder (ASD). Health Net provides the BHT services.
- Diagnosis and, if possible, etiology.

PCPs are responsible for referring infants and toddlers identified as needing early intervention services to the local DDS Early Start program for evaluation within two business days of determination of need, as required by federal law. PCPs provide or arrange for all medically necessary services, including preventive care, referral for specialty or subspecialty consultation, and therapy services necessary to correct or ameliorate identified conditions.

Eligible infants and toddlers and their families may receive service coordination and developmental services from the local regional center or education agency, depending on the condition. PCPs participate or consult with staff

of the local regional center or LEA in the development of the Individual Family Service Plan (IFSP).

IDENTIFICATION OF CONDITIONS

PCPs need to identify infants and toddlers (from birth to 36 months) who may benefit from services provided by DDS Early Start program. These children may have the following risk conditions:

- Significant developmental delay in one or more of these areas:
  - Cognitive.
  - Physical and motor.
  - Communication.
  - Emotional and social.
  - Adaptive.
- Established risk conditions expected to result in developmental delay, including:
  - Chromosomal disorders.
  - Inborn errors of metabolism.
  - Neurological disorders.
  - Toxic exposure.
  - Genetic/congenital disorder.
  - Infection or disease of the central nervous system.
  - Brain malformation or brain injury.
  - Visual or hearing impairments.
  - Family history of developmental delay.
- Are at high risk of having a substantial developmental disability due to a combination of biomedical risk factors:
  - Prematurity less than 32 weeks and/or birth weight < 1500 grams.
  - Ventilator greater than 48 hours.
  - Small for gestational age.
  - Asphyxia neonatorum associated with a five minute – Apgar of 0 to 5.
  - Multiple congenital anomalies.
  - Failure to thrive.
  - Persistent hypertonia/hypotonia.

When determining the need to make a referral to the DDS Early Start program for services, consider:

- Stability of the infant's or toddler's medical condition.
- Readiness of the infant and family to benefit from services.
- Need for additional assessments to document developmental delay or disability.

REFERRALS TO EARLY START PROGRAMS

Referrals to the local DDS Early Start program are made through the local regional centers. Health Net may provide either written or phone referrals to the local regional center, education agency or other locally-designated agency.

REFERRAL COORDINATION WITH CCS

In situations where the child is eligible for both CCS and DDS Early Start programs, the primary referral is to CCS

if diagnosis or treatment for CCS-eligible conditions is the primary concern. The PCP must notify CCS and the regional center simultaneously if both medical and Early Start programs services are indicated.

COORDINATION OF CARE

Health Net assists PCPs and families with referrals of identified children under age 3 who may be eligible to receive services from the DDS Early Start program. Assistance may include contacting the local regional center administrative staff of the local Early Start program by phone or letter, or following up with the family, PCP or regional center to ensure the referral is complete and services are accessed.

Once the referral has been made, the PCP:

- Provides medically necessary covered diagnostic, preventive and treatment services identified in the individual family plan developed by the Early Start program.
- Consults and provides appropriate reports to the Early Start program intervention team.
- Continues case management with assistance from the Medical Management Department when necessary.

PUBLIC PROGRAMS COORDINATION

On an annual basis, except when a member changes their PCP or clinic assignment, the health plan automatically generates a letter notifying their PCP that the member received services from the Early Start Program.

Health Net's Public Programs Department is available to participate in the community Local Interagency Coordination Areas (LICA). Health Net's Public Programs Department works with regional centers to enhance collaboration and coordination.

Local Education Agency Services

LEA services are excluded under the health plan but are paid and coordinated through the Medi-Cal FFS program.

LEA ASSESSMENT SERVICES

The LEA provides certain health care services via school programs. LEA services may include:

- Targeted case management.
- Physical and mental health evaluation.
- Education and psychosocial assessments.
- Health and nutrition education.
- Developmental assessments.
- Behavioral health screenings and treatment services.
- Behavioral health wellness programs and services.

PCPs are encouraged to inform members of these services; however, members may obtain services without a referral from their PCP. PCPs should, whenever possible, coordinate needed medical services with LEA providers to promote continuity of care and ensure proper and timely follow-up. LEA medical services may include:

- Physical and occupational therapy.
- Speech pathology and audiology.
- Psychology and counseling.
- Nursing services.
- School health aide services.
- Medical transportation.

- Behavioral health screenings and treatment.
- Behavioral health wellness programs and services.

PCPs may be asked to support LEAs with the following:

- Written prescriptions for specific LEA services.
- Medical evaluations or records on request.
- Referrals for appropriate and necessary medical services.
- Medically necessary services when school is not in session.

On request, the PCP may authorize LEA providers to provide other services on a case-by-case basis.

Long-Term Care

Medi-Cal members in need of long-term care (LTC) facility services should be placed in facilities providing the level of care commensurate with their medical needs.

- Skilled nursing facility (SNF) for short and long-term care.
- Intermediate care facility (ICF).
-
- Adult subacute care facility.
- Pediatric subacute care facility.

Turnaround times are as follows:

- Authorization 72 hours.
- Placement requirements are five business days for Los Angeles and Sacramento counties, seven business days for San Joaquin and Stanislaus counties, and 14 business days for all other counties.

Hospice services are not considered long-term care services. When hospice services are provided in a long-term care facility, the member's eligibility under the Medi-Cal managed care is not affected regardless of the member's expected or actual length of stay in the nursing facility.

SUBACUTE CARE FACILITIES

Members in need of adult or pediatric subacute care services must be placed in a health care facility that is licensed for subacute care with the California Department of Public Health and providing the level of care commensurate with their medical needs.

Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

Subacute patients require special medical equipment, supplies and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.

IDENTIFICATION

The two primary methods of identifying hospitalized Medi-Cal members who may require LTC are:

- Physician identification – The member's PCP or specialist makes a diagnosis that requires services in an LTC facility. The physician then contacts the Health Net Utilization Management (UM) Department or PPG, if UM responsibilities have been delegated to the PPG, to request prior authorization for admission.
- Care management concurrent review – Health Net or the subcontractor's concurrent review nurses review daily census reports that identify members who may need LTC services following discharge.

Other means of identifying a candidate for LTC services are reviewing retroactive claims for LTC services or through social workers, discharge planners and other health care providers involved in the member's care.

COORDINATION OF CARE

The PCP continues to provide care during the transition to LTC and coordinates with the LTC attending physician to ensure continuity of care. This includes forwarding all pertinent records to the new PCP when identified and available to consult. For coordination of benefit questions, providers may contact the Health Net Public Programs Department.

Major Organ Transplants for Members Ages 21 and Over

Subject to prior authorization, all transplants, as well as all pre- and post-operative transplant-related costs, not limited to evaluation, hospitalization, transportation, and drugs that are not covered by Medi-Cal Rx, are covered under the Health Net Medi-Cal contracts. There is no PPG delegation for Medi-Cal transplants.

Health Net covers the cost of medically necessary, non-experimental and non-investigative organ and stem cell transplants at a Medi-Cal approved Center of Excellence (COE) transplant program which operates within a hospital setting.

Health Net must provide prior authorization for requests for transplant services on an expedited, 72-hour basis, or less if the member's condition requires it or if the organ or bone marrow the member will receive is at risk of being unusable due to any delay in obtaining prior authorization or delay in obtaining the organ or bone marrow.

REFERRAL PROCESS

A PCP, specialist or participating physician group (PPG) who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Medi-Cal-approved Health Net Transplant Performance Center (Center) for transplant evaluation.

The Center must submit a prior authorization request for the evaluation to the Centene Centralized Transplant Unit (CTU) through the provider portal, or via fax directly to the CTU at 833-769-1141. On receipt of a request for an evaluation, the CTU contacts the Center to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number for the evaluation.

Once a member has completed an evaluation and is approved by the Center for transplant, the Center must submit a prior authorization request for listing to the Centene CTU through the provider portal, or via fax directly to the CTU at 833-769-1141. On receipt of a request for a listing, the CTU contacts the provider to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number.

CAR-T cell therapy, corneal transplant, tissue transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy requests must be submitted directly to Health Net. The CTU reviews all solid organ and stem cell transplants including human leukocyte antigen (HLA) typing for stem cell, donor search and stem cell harvest and collection.

Transplants for Members Under Age 21

All transplant services for Medi-Cal members under age 21 are coordinated through the CCS program. Health Net is not responsible for payments related to any transplant or post-transplant care, as these services are carved out to the CCS program.

REFERRAL TO CCS

Medi-Cal members under age 21 with CCS-eligible conditions who require transplant services must be referred to CCS. Health Net assists the PCP to ensure timely referral to the CCS program.

Refugee Health Programs

The DHCS administers the Refugee Medical Assistance program for California. Using county-level refugee health coordinators and programs, the DHCS Local Assistance Branch, Refugee Health Section, ensures every refugee, on initial entry into California, is given a complete health assessment and screening and, if needed, follow-up treatment and care. Services available through the Refugee Medical Assistance program are excluded from Health Net's coverage responsibilities under the health plan.

MEMBER IDENTIFICATION

Members requiring refugee health services may be identified through:

- Community-based organizations.
- Initial health appointments.
- Inpatient admissions (concurrent review).
- PCPs and specialists.
- Care management services.
- Emergency room and urgent care use information.
- Health Net Public Programs Coordination, Medi-Cal Member Services, Health Education or Provider Relations departments, or Health Net's Medi-Cal Provider Services Department.
- Authorization data.
- Claims and encounter data.
- School-based clinics.
- Out-of-network providers.

Due to the importance of timely identification of newly arrived refugees, especially for the reporting of communicable diseases, Health Net collaborates with local refugee health programs to identify refugees who are possible candidates for local refugee health clinic services.

PCP RESPONSIBILITIES

Upon identification of a refugee, the PCP should refer the member to the local refugee health clinic. The PCP must submit required reporting information to the LHD within the timetable in Title 17, CCR Section 2500, *Reporting to the Local Health Authority*. Information reportable to the LHD includes:

- Patient demographics (name, age, address, home phone number, date of birth, gender, ethnicity, and marital status).
- Locating information (employer, work address and phone number).
- Disease information (diseases diagnosed, date of onset, symptoms, laboratory results, and medications prescribed).

- Documentation regarding preventive care health education provided at the time of a routine exam for all members with high-risk behaviors for STI or TB infection.

PCPs may refer members to LHD clinics for receipt of TB care. The PCP must also ensure that the documentation is placed in the member's medical record.

TRACKING AND COORDINATION OF CARE

Health Net's Public Programs Department maintains regular contact with the Refugee Health Medical Assistance Program. The Medical Management staff is available to provide assistance with coordination of care if indicated by the member's condition or requested by the PCP or the Health Net Public Programs Department.

OUT-OF-NETWORK COORDINATION

If a member is seen by a nonparticipating provider or an LHD who calls the Health Net Medi-Cal Member Services Department, the representative gives the nonparticipating provider or the LHD claims submission instructions and instructs the nonparticipating provider or LHD on how to send the report to the member's PCP.

Regional Center Coordination

Regional centers are private, non-profit community-based agencies under contract to the State Department of Developmental Services (DDS). Their purpose is to provide or coordinate services and support for children and adults with developmental disabilities and provide early intervention services for children with developmental delays and disabilities. They provide a local resource to help find, plan, access, coordinate, and monitor the services and support to individuals and their families.

PCPs must provide eligible Medi-Cal members identified with, or suspected of having, developmental disabilities with all medically necessary screenings, primary preventive care, and diagnostic and treatment services. For members at risk of parenting a child with a developmental disability, Health Net covers genetic counseling and other prenatal genetic services.

PCP also arranges for the provision of medically necessary Behavioral Health Treatment (BHT) services even without a diagnosis of Autism Spectrum Disorder (ASD). Health Net provides the BHT services.

ELIGIBILITY DETERMINATION

Prior to receiving services from a regional center, a member must be determined to be eligible under one of the following categories:

- Developmental disability – A developmental disability is one that originates before age 18, continues, or can be expected to continue indefinitely, and is a substantial disability. Developmental disability includes intellectual disabilities, cerebral palsy, epilepsy, autism, and disabling conditions closely related to an intellectual disability or requiring treatment similar to that required by people with intellectual disabilities.
- Infants and toddlers (ages 0–36 months) who are at risk of having developmental disabilities or who have a developmental delay may also qualify for services.
- Individuals at risk of parenting a child with a developmental disability may be eligible for genetic diagnosis, counseling and other preventive services.

There are no financial eligibility requirements for regional center services; however, parents are required to pay based on a sliding fee scale for out-of-home placement for children under age 18. Families are responsible for primary medical and health care for their children, as well as those services normally provided to a child without disabilities. All persons receiving services must be California residents and must apply to the regional center in whose catchment area they reside.

REFERRAL PROCESS

Individuals having, or suspected of having, a developmental disability may be referred to the regional center nearest the applicant's residence. Referrals from the PCP are directed to the intake coordinator at the regional center and must include the reason for referral; complete medical history and physical examination, including appropriate developmental screens; the results of developmental assessments and psychological evaluations; and other diagnostic tests.

A regional center interdisciplinary team reviews the referral information to determine regional center eligibility and considers the need for developmental programs or family support services and the need for additional diagnosis or assessments.

When the Health Net Medi-Cal Medical Management Department or health assessment coordinators identify a member as eligible for a regional center service, they contact the PCP or specialist to determine if the member and the family have been informed of the available regional center services.

If a member was previously referred to or accepted by the regional center, the care manager assesses the case to determine whether further coordination services are needed. If services are no longer required, the Medical Management Department contacts the parent or guardian for approval to discuss the member's case with the regional center. At the parent or guardian's request, Health Net's Medical Management Department may coordinate the family service plan with the regional center's care manager or service coordinator.

REFERRAL COORDINATION WITH CCS

In situations where the child is eligible for both CCS program and regional center services, the first referral is to CCS if diagnosis or treatment for CCS-eligible conditions is the major concern. The provider may want to notify CCS and the regional center simultaneously if both medical and early intervention services are necessary.

PCP RESPONSIBILITIES

PCPs provide the following services for members who are clients of a regional center:

- Referral to specialists and subspecialists for treatment of complex medical problems.
- Referral to mental health care providers for diagnosis and treatment of mental health disorders outside the scope of the PCP's practice.
- Identify members under age 21, with potential or confirmed ASD, and refer to contracted Health Net autism service provider for evaluation or treatment.
- Referral to state-approved services when in need of prenatal genetic diagnostic services.
- Documentation of all activities related to the referral in the member's medical record.

REGIONAL CENTER RESPONSIBILITIES

Regional centers are not responsible for provision of direct medical or health care services, but do provide care management or service coordination for their clients, assuring health, developmental, social, and educational services throughout the lifetime of members who have a developmental disability. The following are some of the services and support provided by the regional centers:

- Information and referral.
- Assessment and diagnosis.
- Counseling.
- Lifelong individualized planning and service coordination.
- Purchase of necessary services included in the individual program plan.

- Resource development.
- Outreach.
- Assistance in finding and using community and other resources.
- Advocacy for the protection of legal, civil and service rights.
- Early start program.
- Genetic counseling.
- Family support.
- Planning, placement and monitoring for 24-hour out-of-home care.
- Training and educational opportunities for individuals and families.
- Community education about developmental disabilities.

PUBLIC PROGRAMS COORDINATION

On an annual basis, except when a member changes their PCP or clinic assignment, Health Net automatically generates a letter notifying their PCP that the member received services from the regional center.

Chapter 7 – Public Health Waiver Programs

Public health programs provide a wide variety of services to Medi-Cal members at the county, state and federal level. Physicians, public health programs and Health Net coordinate their efforts to assist Medi-Cal beneficiaries in receiving the full scope of available benefits and services. Waiver programs are case management programs for people with specific health problems. Health services provided to Medi-Cal members through a waiver program are coordinated and paid by sources other than Health Net.

Members receiving services through one of the waiver programs usually disenroll from the health plan. However, members are allowed the option of remaining enrolled with Health Net if their needs do not require the full scope of the waiver program services. This chapter details the waiver programs available to members, eligibility requirements, referral and authorization processes, and care coordination requirements.

For clarification, the Carve-Out and Waiver Programs matrix, included on page 87, lists the public health programs available to Medi-Cal members and indicates the type of program; status of member enrollment when these services are accessed; and payer, referral and authorization sources (carve outs are discussed in Chapter 6).

Unless otherwise noted, disputes or problems that arise between the public health programs described in this chapter and Health Net or the primary care physician (PCP) are handled by Health Net's Public Programs Department. During any such period, the Medical Management staff and the PCP or specialty provider continue to coordinate the care of the member.

Medi-Cal Waiver Program, Formerly Known as the AIDS Waiver Program

The Medi-Cal Waiver Program (MCWP), formerly known as the AIDS Waiver, provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their primary care provider, family, caregivers, and other service providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution.

The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care;
- Increase coordination among service providers and eliminate duplication of services;
- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and,
- Enhance utilization of the program by underserved populations.

Clients eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

ELIGIBILITY

Members must meet the CDPH's Medi-Cal Waiver program eligibility requirements to participate through Health Net. Managed care members are not required to disenroll from Health Net in order to enroll in the Medi-Cal FFS

Medi-Cal Waiver program. To qualify, members with AIDS or symptomatic HIV disease must meet the CDPH's criteria:

- Be Medi-Cal enrolled.
- Have a written diagnosis of HIV disease or AIDS with current signs, symptoms or disability related to the HIV disease or treatment.
- Children under age 13 who are identified by the CDPH nurse case manager as HIV/AIDS symptomatic (Note: Children who are HIV-positive must be referred to the California Children's Services (CCS) program.).
- Adults who are certified by the CDPH nurse case manager to be at nursing facility level of care and score 60 or less on the cognitive and functional ability scale assessment tool.
- Individuals with health status consistent with in-home services and who have home settings safe for both members and service providers.
- Have exhausted other coverage, such as private health insurance for health care benefits similar to those available under the Medi-Cal Waiver program prior to use of Medi-Cal Waiver program services.
- Must not be simultaneously enrolled in Medi-Cal hospice but may be simultaneously enrolled in Medicare hospice.
- Must not be simultaneously enrolled in the AIDS Case Management program.
- Must not simultaneously receive case management services or use State Targeted Case Management Services program funds to supplement the Medi-Cal Waiver Program (MCWP).
- Must have an attending PCP willing to accept full professional responsibility for the recipient's medical care.

MEDI-CAL WAIVER PROGRAM CARE MANAGEMENT

The CDPH's Medi-Cal Waiver program agencies provide services only in non-institutional settings. The home is the most common place of service. The CDPH contracting agencies are responsible for administering the program, providing nurse care management and authorizing payment to Medi-Cal Waiver program services subcontractors.

The CDPH's Office of AIDS contracts with agencies throughout California to administer the Medi-Cal Waiver program and provide nurse care management services. These agencies subcontract with licensed providers for program services.

CDPH's Medi-Cal Waiver program care management team locates, coordinates and monitors services for enrollees. This includes developing a written service plan and assessing the service requirements and medical condition of the enrollee. Medi-Cal Waiver program care management is performed by a team that includes a program nurse care manager, social worker or foster child case-worker (if needed), attending physician, and member.

The CDPH's Medi-Cal Waiver program care manager may authorize Medi-Cal FFS in-home skilled nursing care, attendant care, homemaker care, psychosocial counseling, equipment and minor physical adaptations to the home, Medi-Cal supplement for infants and children in foster care, non-emergency medical transportation, nutrition counseling, nutritional supplements, and home-delivered meals.

REFERRAL AND COORDINATION OF CARE

The PCP, Medical Management staff or both inform eligible members about the Medi-Cal Waiver program. If the member believes she or he is eligible and requests program referral, the type of supportive care needed is identified and the Medical Management or public programs staff initiates a referral.

The California Department of Public Health's Office of AIDS conducts assessment of the member based on the CDPH's Medi-Cal Waiver program criteria for enrollment eligibility.

With the member's consent, the PCP or Health Net's Medical Management staff forwards any available relevant

medical documentation to the program, including the member's medical history, lab results and an outline of the therapeutic regimen. For members who elect to remain enrolled in both the plan and Medi-Cal Waiver program, the Medical Management staff concurrently institutes a care management plan and coordinates with the member's PCP.

The member's PCP and Health Net's Medical Management staff are responsible for developing a primary care management plan that covers all medically necessary treatment and meets the health care needs of the member diagnosed with AIDS. They are responsible for coordinating and authorizing pharmacy services under the medical benefit, inpatient services, outpatient services, infusion services, laboratory, specialty referrals, durable medical equipment (DME), preventive care services, and respiratory care services.

If the member elects to disenroll from the plan, the Medical Management staff contacts the Health Net Medi-Cal Member Services Department to initiate the disenrollment. The Medical Management staff is responsible for authorization of services and coordination of the member's medical care until the member enters the Medi-Cal Waiver program.

Home and Community-Based Services Waiver Administered by the Department of Developmental Services

The primary goal of the Department of Developmental Services (DDS)-administered Home and Community-Based Services (HCBS) Waiver program is to ensure consumer choice of waiver services and consumer satisfaction, and to provide safeguards necessary to ensure the health and safety of each consumer in the program. The DDS-administered HCBS Waiver program includes an array of services designed to support those with development disabilities in either a home or community-based setting as an alternative to care in a care facility for the developmentally disabled. The HCBS Waiver program is available to developmentally disabled persons regardless of their age. A developmental disability is defined as a disability that originates before an individual attains the age of 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual.

As of January 1, 2024, the Plan provides all medically necessary covered services for members residing in or obtaining care in an ICF/DD Home, including home services, professional services, ancillary services, and transportation services. The Plan ensures members in need of ICF/DD home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. The Plan must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services.

DDS-ADMINISTERED HCBS WAIVER PROGRAMS

The DDS has administrative responsibility for the state's five developmental centers and 21 regional centers. DDS oversees the regional centers and administers the HCBS Waiver program. The DDS-administered HCBS waiver program provides specialized services in the member's family home.

The regional center service coordinator is responsible for determining the DDS HCBS Waiver setting that is best for the eligible developmentally disabled member. Although the regional centers provide overall care management, they are not responsible for direct medical services. During the member's participation in the DDS-administered HCBS Waiver program, a Health Net-participating PCP continues to provide all primary care and other medically necessary services.

ELIGIBILITY

To be eligible for Regional Center services, an individual must have a developmental disability that originates before 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the director of DDS, in consultation with the Superintendent of Public Instruction, this

term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability but shall not include other handicapping conditions that are solely physical in nature.

REFERRALS TO HCBS

Health Net coordinates referrals to the regional center when notified of a member with a potential need for supportive care and facilitates medical records from the member's PCP for the DDS HCBS Waiver program.

COORDINATION OF SERVICES

Once Health Net determines a member may meet the requirements for participation in the DDS-administered HCBS Waiver program, Health Net initiates a referral. A regional center service coordinator is assigned to coordinate waiver services. Receipt of DDS-administered HCBS services does not require a member to be disenrolled from the health plan. The PCP continues to provide all medically necessary covered services and coordinates the member's care. Health Net is responsible for coordinating with the regional center care manager and the PCP in the development of the member's individual service plan and individual education plan.

If the member is currently receiving services through the DDS program, Health Net coordinates services with the PCP and regional center service coordinator as needed.

If the member does not meet the criteria for the waiver program or if placement is unavailable, Health Net's PCP continues to manage care and provide all medically necessary services to the member.

HCBS WAIVER PROGRAMS

Home and Community-Based Services (HCBS) Waivers allow states that participate in Medi-Cal in California to develop creative alternatives for individuals who would otherwise require care in a nursing facility or hospital. Medi-Cal has an agreement with the federal government, which allows for waiver services to be offered in either a home or community setting. The services offered under the waiver must cost no more than the alternative institutional level of care.

ELIGIBILITY

To qualify for potential enrollment into the HCBA waiver, members must meet the following criteria:

1. Must have full-scope Medi-Cal eligibility
2. Physically disabled (no age limit)
3. This waiver will serve Medi-Cal beneficiaries, who in the absence of this waiver, and as a matter of medical necessity, would require care in an inpatient nursing facility (NF) providing the following types of care:
    - Nursing Facility (NF) B level of care
    - NF A level of care
    - NF Level B pediatric Services
    - NF subacute services
    - NF pediatric subacute services

The Health Net Population Health Department monitors and reviews all inpatient stays for proper use and to identify members who may benefit from Home and Community Based Services (HCBS) Waiver programs.

REFERRALS TO HCBS

The PCP needs to inform the member, guardian or authorized representative about the availability of in-home care alternatives. On consent of the member, guardian or authorized representative, the Population Health Department coordinates with the inpatient facility discharge planner and care manager to refer the member to a licensed and Medi-Cal-certified home health care agency for evaluation. The home health agency's care managers evaluate the member's health care needs and whether they can be met in the member's home.

Multipurpose Senior Services Program Waiver

The Multipurpose Senior Services Program (MSSP) Waiver provides social and health care case management services for members ages 65 and older who wish to remain in their homes and communities. The goal of the program is to use available community services to prevent or delay institutionalization. The services must be provided at a cost lower than that of a skilled nursing facility. MSSP services include, but are not limited to:

- Environmental accessibility adaptations.
- Personal emergency response systems (PERSs) and communication devices.
- Care management.
- Personal care services (bathing, dressing, grooming).
- Respite care (in- and out-of-home).
- Adult day care, support center and health care.
- Housing assistance and minor home repair.
- Chore services.
- Income maintenance counseling.
- Mental health services.
- Transportation services.
- Protective supervision.
- Meal services.
- Communication services (translation or interpreter).

ELIGIBILITY

To qualify for the MSSP, Medi-Cal members must meet all of the following criteria:

- Be age 65 or older.
- Certifiable for placement in a skilled nursing facility (SNF).
- Live in a county with an MSSP site and be within the site's service area.
- Be appropriate for care management services.
- Able to be served within MSSP's cost limitations.

REFERRAL PROCESS

Members who are potentially eligible to receive MSSP services may be identified through a variety of sources, including community-based organizations, the member's PCP or specialist, concurrent review of inpatient admissions, or claims and encounter data.

The PCP and other providers continue to render medically necessary care while the member participates in the MSSP.

Chapter 8 – Health Care Management

Comprehensive care management is necessary when a member has multiple problems or diagnoses resulting in a high-risk catastrophic or fragile medical condition. Health Net's care management program involves identifying medical need and allocating resources.

Health Net complies with applicable federal civil rights laws and ensures that all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

Case management, continuity of care, utilization management, credentialing, and quality improvement programs are outlined in this chapter.

CASE MANAGEMENT

The program is based upon a model that uses a multi-disciplinary care management team, recognizing that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the primary care physician (PCP) or specialist office with administrative work.

There are two different levels of case management:

- Basic case management.
- Comprehensive case management.

Basic Case Management

At the basic level, care management is the responsibility of the PCP. The PCP is responsible for providing initial primary care management, maintaining continuity of care and initiating specialist care. This means providing care for the majority of health problems, including preventive care services, basic care management, acute and chronic conditions, and psychosocial problems.

Comprehensive Case Management

Comprehensive case management is a collaborative process through which a Health Net registered nurse (RN), licensed behavioral health clinician or social worker assesses, plans, coordinates, monitors, and evaluates the options and services needed to meet a member's health needs and promote a positive health outcome in cooperation with the entire treatment team. This program supports the Health Net member, family and caregivers by coordinating care and facilitating communication between health care providers. Additionally, the Health Net case management team has experience with the population, the barriers and obstacles they face, and how socioeconomic factors impact their ability to access services.

The Health Net case management team manages care for members whose needs are functional and social as well as those with complex physical and or behavioral health conditions. Health Net uses a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices. Case managers partner with the PCP to support members to help them achieve their self-management health care goals.

Comprehensive case management encompasses:

- Physical health case management.
- Behavioral health case management:

  - Health Net coordinates the mild-moderate behavioral health benefit for members, including behavioral health treatment services.
- Integrated case management:
  - Behavioral health and physical health case management services are fully integrated.
  - Co-managed based on the primary driver of health status; one point of contact with the member.
- Pregnancy case management.

Comprehensive case management manages members who are experiencing acute and severe events, such as:

- Complex chronic conditions, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), and vascular disease or active cancers.
- Multiple comorbidities.
- A health event that has the potential for significant consumption of resources (medical or financial).
- Complications relating to frail physical or mental health status.
- Pregnancy.
- Those experiencing frequent or prolonged hospitalizations or emergency visits.
- Multiple psychosocial factors, such as need for support system, transportation, financial resources, decision support, habilitation, or residential needs.
- Functional impairment, such as dependency for activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
- Individuals who are eligible by law, such as those with mental or developmental disabilities.

In addition, Medi-Cal managed care members with the following medical conditions and/or receiving the following services must be referred to case management for referral to the applicable state or county program:

- Transplant cases for members under age 21.
- Multiple congenital birth defects.
- Pre-term births, including those eligible for high-risk follow-up from California Children's Services (CCS).
- Members with AIDS.
- Children with special health care needs eligible for Regional Center care.
- Children with CCS-eligible conditions.
- Children over age 3 with speech/language delay.
- Members under the age of 21 who have been approved to receive private duty nursing services.

Additional information regarding eligibility requirements for public health programs, such as Regional Centers and CCS, is provided in the Public Health topic.

Members are proactively identified by Health Net utilizing a predictive modeling tool, health risk screenings and internal reports. Members may also be referred by internal sources as well as external sources, including health care providers, community/county programs, a state agency, parent, or caregiver. Members may self-refer to the program by calling the member services phone number on the back of their identification (ID) card.

REFERRAL TO CASE MANAGEMENT

The referral is made to the Health Net Case Management Department. Indicators that a member may be appropriate for care management may be based on diagnosis, potential treatment, frequent hospitalizations,

extended hospitalizations, location of care, and patterns of care. To refer a member for case management, use the Care Management Referral Form located in the Forms and References section of the Provider Library. Members with urgent behavioral health needs can be referred directly to a participating behavioral health provider in the Health Net network, or to the local county mental health plan for more severe symptoms and risk factors.

PALLIATIVE CARE SERVICES

Eligible members at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), COPD or liver disease. Life expectancy is 12 months or less, health status continues to worsen and the emergency department or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

REFERRALS

Palliative care services provide extra support to current benefits. The plan's palliative team and approved palliative care providers work with other health care team members and services to coordinate palliative services with ongoing medical services.

Providers can refer an eligible Medi-Cal member to palliative care. Complete and send an Outpatient California Medi-Cal Prior Authorization Form and related medical records, by email or fax to the Prior Authorization Department. The form is located in the Forms and References section of the Provider Library.

PCP RESPONSIBILITIES

The PCP continues to be the principal person responsible for directing the member’s care. The Health Net care manager provides the PCP with reports regarding the member’s progression through the care management plan. The PCP is responsible for:

- Providing ongoing medical treatment.
- Providing health care information, such as medical records and treatment plan, to expedite health care services for the member.
- Participating as a health care team member in the member’s care management plan.
- Attending care conferences to evaluate the member’s progress and modify the care plan, if necessary, and/or reviewing the care management plan of care and providing feedback to the care manager.
- Maintaining complete documentation in the member’s medical record.

CARE MANAGEMENT FOR CARVE-OUT SERVICES

Some services, such as major organ transplant for members under age 21, have been carved out of the health plan and are not covered by Health Net under its Medi-Cal managed care contract with the DHCS. Transplant cases for members under age 21 are managed by the state. County care management programs include CCS, waiver and regional center programs. Refer to the detailed description of the individual program as discussed in chapter 6, Public Health Carve-Out Services and chapter 7, Public Waiver Programs of this guide. For a complete list of carve-out services refer to Member Handbook.

REFERRALS TO STATE OR COUNTY CARE MANAGEMENT PROGRAMS

When a member is identified as eligible for a county- or state-supported health care program, a Health Net care manager or review nurse assists the PCP, on request, in ensuring timely referral. The PCP makes the referral and coordinates primary medical care for members who are eligible for any of the carve-out programs. Health Net’s care managers also serve as liaisons between the PCP and the county carve-out services coordinator to ensure the

exchange of information and provision of primary health care for individual members.

Care Coordination

Care coordination refers to the system of directing and monitoring a member's care among multiple health care providers, encounters and procedures so that the member receives timely, medically necessary health care services without interruption.

The system comprises several procedural components that are required based on the extent of the severity of the member's health condition. Basic procedures required of PCPs to maintain care coordination are:

- Documentation of member encounters, missed appointments, extensions of appointment waiting times, and referrals in the member's medical record.
- Referral of members needing specialty health care services.
- Forwarding summaries of pertinent medical findings to specialists.
- Documentation of services provided by specialists in the member's primary care medical record.
- Monitoring members with ongoing medical conditions.
- Notifying Health Net of member referrals to specialists, care management and public health programs.

Additional procedures are required of the PCP when the member's health condition requires urgent, emergency or inpatient health care services, including:

- Documentation in the member's medical record of emergency and urgent medical care and follow-up.
- Coordinated hospital discharge planning.
- Post-discharge care.

Health Net suggests that each provider develop protocols to maintain care coordination. A log system for tracking prior authorizations, referrals to specialists, follow-up of missed appointments, and acknowledgment and verification of such things as lab and X-ray findings is recommended. The system can be manual or computerized.

NOTIFICATION REQUIREMENTS

Public Health Agency Referral Notification

Providers must report to Health Net all Medi-Cal members who have been referred to the Medical Management Department, excluding those referred for sensitive services, such as HIV testing and counseling, family planning, and alcohol and drug abuse treatment. Notification to the Medical Management Department may be made via mail or fax and must include the following information:

- Member name.
- Member identification (ID) number.
- Provider name.
- Type of referral.
- Date of referral.
- Diagnosis (for CCS only).

Care Management Notification

Report all admissions with an ELOS greater than 10 days and all cases identified meeting provider stop loss criteria to the Health Net Hospital Notification Unit.

MISSED APPOINTMENTS

Appointments may be missed due to member cancellation or no show. The DHCS requires the provider to attempt to contact the member a minimum of three times when he or she misses an appointment. Attempts to contact must include:

- First attempt – phone call to member (or a written letter must be sent if the member does not have a phone).
- Second attempt – if the member does not respond to the first attempt, a second telephone call must be made to the member (or a written letter must be sent if the member does not have a phone).
- Third attempt – if the member does not respond to the second attempt, a written letter must be sent.

For members under age 21, failure to respond to the PCP's follow-up attempt must be reported to Health Net's Public Programs Department.

Documentation must be noted in the member's medical record regarding any missed or canceled appointments, reschedule dates and attempts to contact.

MISSED PROCEDURE OR LABORATORY TEST

Appointments for procedures or tests may be missed or canceled. The provider must contact the member by phone or letter to reschedule. Documentation must be noted in the medical record regarding any missed or canceled procedures or tests, reschedule dates, and any attempts to contact the member.

CHANGE IN MEMBER STATUS

The PCP must develop office procedures to remain informed about changes in the member's status (for example, the member has changed PCP, been hospitalized or died) with notation in the medical record.

The PCP may obtain this information from member enrollment data. Further, the PCP should receive information regarding hospital admissions within 24 hours or one business day when an admission occurs on a weekend from the facility, the member, participating physician group (PPG), or Health Net (or affiliated health plan in Los Angeles County).

SERVICES RECEIVED IN AN ALTERNATE CARE SETTING

The PCP should receive a report from the rendering provider with findings, recommended treatment and results of treatment for services performed outside the PCP's office. The PCP may also receive emergency department reports, hospital discharge summaries and other information. Home health agencies submit treatment plans to the PCP after an authorized evaluation visit and every 30 days afterward for review of home health care and authorization. The PCP should also receive reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action.

Utilization Management

The Health Net utilization management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are elements of the UM process.

TIMELINESS REQUIREMENTS FOR UTILIZATION REVIEW DECISIONS

Health Net and its PPGs to which UM functions have been delegated are required to comply with the following standards for UM decisions (refer to the Health Net Medi-Cal provider operations manuals for additional information on timeliness requirements when extensions are needed).

Prior Authorization of Routine (Non-Urgent) Care

Prior authorization of routine (non-urgent) care requests must be determined within five business days of receipt of all the information reasonably necessary to make a decision.

The requesting provider must be informed of these decisions via phone or fax within 24 hours after the decision is made. Follow-up written notification of denials or modifications must be made within two business days of the decision.

Expedited Prior Authorization for Urgent Care

Expedited prior authorization occurs when the requesting provider determines that the standard decision-making time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. These decisions must be determined within 72 hours of receipt of the request.

The requesting provider must be informed of these decisions via phone or fax within 24 hours after the decision is made. Follow-up written notification of denials or modifications must be made within two business days of the decision.

Hospice Inpatient Care

Prior authorization of hospice inpatient care must be made within 24 hours of receipt of request.

Concurrent Review

Concurrent review decisions for treatment regimens already in place (such as inpatient or ongoing/ambulatory services) must be determined within five business days or less, consistent with the urgency of the member's medical condition.

The treating provider must be notified of the decision within 24 hours after the decision is made. Follow-up written notification of denials or modifications must be made within two business days of the decision.

Post-Service/Retrospective Review

Retrospective review decisions must be made within 30 calendar days of receipt of all the information reasonably necessary to make a decision.

The treating provider must be notified of these decisions within 30 calendar days of receipt of the request.

HOSPITAL AND INPATIENT FACILITY DISCHARGE PLANNING AND NOTIFICATION

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for Health Net members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization. For any concurrent authorization that is denied, care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The Transitional Care Services at 866-801-6294 is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Hospitals and inpatient facilities must have policies and procedures in place when transitioning members from hospitals or inpatient facilities to their homes and other community-based settings to support effective care transitions. Hospitals and inpatient facilities must notify and communicate with the member's primary care physician (PCP) and Enhanced Care Management (ECM) provider of discharge from hospitals or inpatient facilities. Information regarding each medication dispensed must be given to the member upon discharge.

REQUESTS FOR AUTHORIZATION FOR POST-STABILIZATION CARE AT NON-PARTICIPATING AND PARTICIPATING HOSPITALS

Health Net is responsible for the coverage and payment of emergency services and post-stabilization care services to the provider that furnishes the services. This can be a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Requests for post-stabilization authorization

The requirement to request authorization applies to both in-network and out-of-network hospitals when treating members.

The hospital's request for authorization is required once the member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for inpatient post-stabilization care. A patient is "stabilized," or "stabilization" has occurred, when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Hospitals are required to provide the treating physician and/or surgeon's diagnosis and any other relevant information reasonably necessary for Health Net to decide whether to authorize post-stabilization care or to assume management of the patient's care by prompt transfer.

How to request post-stabilization authorization

To request authorization for post-stabilization care, the hospital must call the Hospital Notification Unit at 800-995-7890.

A hospital's notification to Health Net of emergency room treatment or admission does not satisfy the requirement to request post-stabilization care. Post-stabilization requirements do not apply if the member has not been stabilized after emergency services and requires medically necessary continued stabilizing care.

A hospital's contact with any other phone or fax number or website, or the patient's participating physician group (PPG), to request authorization to provide post-stabilization care does not satisfy the requirements of the above required procedures. Do not contact the member's PPG or any other Health Net phone, fax number or website to request Health Net's authorization for post-stabilization care.

Behavioral health emergencies

For post-stabilization care related to behavioral health for Medi-Cal members, Health Net oversees medical evaluation, stabilization and initial care. However, ongoing care in a facility following a behavioral health emergency falls under the responsibility of County Mental Health Plans. To ensure continuity of care, please contact your County Mental Health Plan for authorization of all facility-based services. They will coordinate and manage continued care once the member has been stabilized and is ready for transition.

County Mental Health Plan information is available through the Department of Health Care Services. Health Net will coordinate with the County Mental Health Plan to transition the member once appropriate.

Response time to requests

Health Net must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is considered authorized.

Failure to request post-stabilization authorization

Health Net may contest or deny claims for post-stabilization care following treatment in the emergency department or following an admission through a hospital's emergency department when Health Net does not have a record of the hospital's request for post-stabilization care via phone or a record that Health Net provided the hospital an authorization for such services.

CCS-eligible conditions (Medi-Cal members)

If a patient's Health Net identification (ID) card indicates enrollment through Medi-Cal, the member is under age 21, and services are related to a California Children's Services (CCS)-eligible condition, the hospital should still request post-stabilization authorization from Health Net's HNU using the procedure described above.

Required documentation

All requests for authorization, and responses to requests, must be documented. The documentation must include, but is not limited to:

- Date and time of the request.
- Name of the provider making the request.
- Name of the Health Net representative responding to the request.

Conditions of financial responsibility

Health Net is financially responsible for post-stabilization care services that are not pre-authorized, but are administered to maintain, improve, or resolve the member's stabilized condition if the Plan:

- Does not approve or disapprove a request for post-stabilization care within 30 minutes.
- Cannot be contacted.
- Is unable to reach an agreement with the treating provider concerning the member's care and a Plan physician is not available for consultation.

If this situation applies, the Plan must give the treating provider the opportunity to consult with a Plan physician. The treating provider may continue with care of the member until a Plan physician is reached or one of the following criteria is met:

- A Plan physician with privileges at the treating provider's hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility for the member's care through transfer;
- The Plan and the treating provider reach an agreement concerning the member's care; or
- The member is discharged.

CLINICAL CRITERIA FOR UTILIZATION AND CARE MANAGEMENT DECISIONS

To determine medical appropriateness, the Health Net UM/care management (CM) program uses recognized guidelines and criteria sets that are clearly documented, based on sound clinical evidence, and include procedures for applying criteria based on the needs of individual members and characteristics of the local delivery systems. For the Medi-Cal program, Health Net uses criteria set forth in applicable sections of Titles 17 and 22 of the California Code of Regulations, Department of Health Care Services (DHCS) Medi-Cal Provider

Manual, and the Hayes evidence-based resources. These criteria are used to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying or denying requests for services.

Health Net also uses InterQual® Criteria, along with other company-wide evidence-based medical policies, which are approved and updated by the Health Net Medical Advisory Council (MAC). Health Net's UM criteria guide the assessment of medical necessity for pre-service outpatient requests, admissions and concurrent stay review in acute and skilled facilities. If conflicting criteria exist, Health Net considers Title 22 to prevail. Health Net makes available its Medical Policies on Health Net's provider website at www.provider.healthnet.com.

PPGs with delegated responsibilities for UM are required to have a written UM program that documents all facets of delegated authority. Prospective, concurrent and retrospective review processes may be delegated to PPG staff, with oversight by Health Net staff. All decisions regarding approval or denial of health care services under delegation are made in accordance with the PPG UM program. PPGs with delegated functions are required to use standardized UM criteria, such as InterQual guidelines, to ensure consistent decision-making at all levels of review.

For additional information on Health Net's policies regarding UM decisions, refer to the Health Net Medi-Cal provider operations manuals in the Health Net Provider Library.

CONTINUITY OF CARE ASSISTANCE

Health Net offers continuity of care assistance to newly enrolled Medi-Cal members for up to 12 months in certain situations. Medi-Cal members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months. An existing relationship means the member has seen the nonparticipating provider at least once during the previous 12 months for a non-emergency condition prior to the date of their initial enrollment with the plan.

A current member may also be approved to complete care with a departing Health Net provider after that provider leaves Health Net's network. Completion of covered services are provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the health plan in consultation with the member and terminated provider or nonparticipating provider and consistent with good professional practice.

Member requests for continuity of care assistance must meet specified criteria. Among such criteria is the requirement that there are no documented quality-of-care issues which Health Net has determined make the provider ineligible to continue providing services to Health Net members. Cases are considered for continuity of care assistance based on evidence of an ongoing relationship with the nonparticipating provider or terminating provider, and plan benefits. The following continuity of care duration criteria apply:

- Pregnancy – for the duration of the pregnancy and the immediate postpartum period (45 days).
  - For members who provide written documentation of being diagnosed with a maternal mental health condition from the member's treating provider, completion of covered services will not exceed 12 months from the member's diagnosis or from the end of pregnancy, whichever occurs later.
  - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
- Surgery or procedure scheduled by a provider who is authorized by Health Net – as part of a documented course of treatment recommended to occur within 180 days of the provider termination date for current Health Net members or effective date of coverage for newly enrolled Health Net members.
- Care of newborn (birth to 36 months) – up to 12 months.
- Completion of covered services is provided for the duration of the acute condition – a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem requiring prompt

medical attention and with a limited duration.

- Serious chronic condition – a medical condition due to a disease, illness or other medical problem or medical disorder serious in nature, and that does either of the following:
  - Persists without full cure or worsens over an extended period of time.
  - Requires ongoing treatment to maintain remission or prevent deterioration.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services are provided for the duration of a terminal illness for current Health Net members, which may exceed 12 months from the provider termination date or 12 months from the effective date of coverage for newly enrolled Health Net members.
- Medically necessary behavioral health treatment for children under age 21. These services include applied behavioral analysis (ABA) – up to 12 months.

REQUESTING CONTINUITY OF CARE

New members, their authorized representatives on file with Medi-Cal or their providers may initiate a request for continuity of care directly from Health Net. When this occurs, Health Net initiates the process of reviewing the request within five business days after receipt of the request.

Health Net completes continuity of care requests within 30 calendar days from the date of receipt, within 15 calendar days if the member's medical condition requires more immediate attention or within three calendar days if there is risk of harm to the member. Risk of harm is defined as an imminent and serious threat to the member's health. Providers may complete the Continuation of Care Request form for members and submit it to the Health Net Medi-Cal Member Services Department.

Quality Improvement

The Health Net Quality Improvement (QI) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and the implementation of actions to improve performance. The scope of these activities takes into account the enrolled populations demographics and health risk characteristics, as well as current national, state and regional public health goals. The QI program impacts the following:

- Health Net members in all demographic groups and in all service areas in which Health Net is licensed.
- Network providers, including physicians, facilities, hospitals, ancillary providers, and any other contracting or subcontracting provider types.
- Aspects of care, including level of care, health promotion, disease management, integrated care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.
- Health disparities through support of activities and initiatives that improve the delivery of health care services and patient outcomes.
- Communication ensuring culturally and linguistically appropriate care.
- Behavioral health aspects of care integration to monitor and evaluate the care and service provided to improve behavioral health care in coordination with other medical conditions.
- Provider performance relating to professional licensing, accessibility and availability of care, and quality and safety of care/services, including provider and office associate behavior, medical recordkeeping practices, environmental safety, and health promotion.
- Services covered by Health Net, including preventive care; primary care; specialty care; ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing

care; home health care; Long-Term Services and Supports (LTSS): Community-Based Adult Services (CBAS); services for Local Education Agencies (LEA); regional centers and local government health programs; and long-term care (LTC) that meets the special, cultural and linguistic needs of all members.

- Inpatient, outpatient and home care, including monitoring and evaluating the care and service provided for quality and meeting cultural and linguistic needs.
- Internal administrative processes related to service and quality of care, including customer service, enrollment services, provider relations, provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

QUALITY IMPROVEMENT (QI) DEPARTMENT

The QI Department establishes programs to meet the regulatory requirements of the Centers for Medicare & Medicaid Services (CMS), DHCS and the Department of Managed Health Care (DMHC). These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site/medical record review audits and certification, along with any necessary follow-up corrective action plans.

This department monitors the results of QI activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also responsible for preparation and implementation of any identified corrective actions based on findings of the CMS, DHCS and DMHC audits and findings through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by individuals who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. Assigned team members are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, they are responsible for ensuring compliance with all CMS, DHCS and DMHC access-to-care standards, monitoring processes and access-to-care action plans.

QI AUDITS OF MEDI-CAL PROVIDERS

Facility Site Review and Medical Record Audits

All PCPs participating in Medi-Cal are required to complete an initial facility site inspection and subsequent periodic facility site inspections regardless of the status of the other accreditation or certification programs as part of the initial credentialing process. The full scope site review includes the facility site review (FSR), physical accessibility review survey (PARS) and the medical record review (MRR).

In an effort to decrease duplicative FSRs and MMRs, and minimize the disruption of patient care at provider offices, Health Net and all other Medi-Cal managed care health plans are required to collaborate in conducting FSRs and MMRs. On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a PCP and administering a corrective action plan (CAP) when necessary. The responsible plan shares the audit results and CAP with the other participating health plans. Practitioners who do not comply with a CAP or fail to meet consecutive threshold scores on an FSR or MRR are forwarded to the Credentialing Committee for administrative termination per DHCS policy. The termination will be applicable to the Medi-Cal line of business for the impacted location only and remain in effect for three years from the date of the committee's final decision. The affected practitioner is afforded rights to an informal appeal (reconsideration) of the committee's decision to administratively terminate.

DHCS reviews the results of site reviews and MMRs and may also audit a random sample of provider offices to ensure they meet DHCS standards.

DISEASE MANAGEMENT PROGRAMS

Disease Management Program aims to identify members at risk for asthma, diabetes and heart failure. The goal of the program is to help improve the care of members with chronic conditions by empowering individuals and working with health care providers to manage their condition and prevent complications. Eligibility is based on review and analysis of claims, encounter, pharmacy, and eligibility data in compliance with the National Committee for Quality Assurance (NCQA) specifications for disease management. Health Net conducts outbound telephonic interventions and referrals to integrated care management for members identified as being at high risk for hospitalizations or poor outcomes.

Health Education

Health Net's Health Education System promotes resources and programs to educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems. Health Education programs and services include:

- **Health education resources.** Members or parents of youth members may order health education materials on a wide range of health topics, such as asthma, healthy eating, diabetes, immunizations, dental care, prenatal care, exercise and more. The materials are available in several threshold languages. Members may obtain more information by contacting the Medi-Cal Member Services Department at 800-675-6110.
- **Tobacco Cessation Program.** Kick It California (formerly California Smokers' Helpline) is a no-cost, state-wide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers telephonic quit coach six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), automated texting programs by texting "Text "Quit Smoking" or "Quit Vaping" to 66819," chat with a quit coach (Kickitca.org/chat), and mobile app (Available for download on the App Store® and Google Play®). Members can learn more by calling Kick It California at 800-300-8086, or online at www.kickitca.org.
- **Healthy Pregnancy.** Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement, and handbooks on planning a healthy pregnancy, caring for your baby, and teen parenting. High risk pregnancies receive additional case management services.
- **Diabetes Prevention Program.** Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.
- **Digital health education.** Members have access to online and digital resources for health education through our Krames Staywell Health Library – Resource library to help you learn about your health and how to stay healthy.
  - Health and Medications – Easy access to more than 4,000 health sheets.
  - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.
- **MyStrength Program.** Available in English and Spanish, members have access to an evidence-based, self-help resource to improve their mental health. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, sleep problems and many other mental health conditions. This program is available at bh.mystrength.com/hnmedical or through the myStrength mobile app.
- **Health promotion incentive programs.** Health Education partners with the Quality Improvement department to develop, implement and evaluate incentive programs to encourage members to receive health education and to access preventive health care services.

- **Community health education classes.** Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- **Community health fairs.** The Plan participates in health fairs and community events to promote health awareness to members and the community. Plan representatives provide screenings, presentations and/or health education materials at these events.

Credentialing and Recredentialing

Health Net's credentialing program establishes criteria and reviews professional qualifications for approving new and evaluating continuing Health Net participating providers.

Providers and practitioners are evaluated for compliance in accordance with the health plan, federal and state regulatory requirements, and accrediting entity standards. Providers and practitioners must be credentialed prior to providing health care services to Health Net members. On an ongoing basis, the recredentialing cycle is consistent with regulatory and NCQA requirements. Practitioners are subject to recredentialing at least every three years.

Only licensed, qualified applicants meeting and maintaining Health Net standards for participation requirements are accepted or retained in Health Net's provider network. The credentialing process is administered by Health Net or subcontracting health plans, agencies or PPGs to which credentialing responsibilities have been delegated in accordance with Health Net criteria. Health Net does not authorize these entities to grant temporary privileges. Health Net retains the right to deny, approve, suspend, limit, or terminate a practitioner agreement through the credentialing process.

Chapter 9 – Claim Billing and Encounter Information

Providers may obtain reimbursement of claims more efficiently by becoming familiar with Health Net's claims procedures. This chapter covers claims, billing and encounter reporting procedures. Processes for tracking the status of a claim or requesting a claim payment adjustment are described. Provider responsibilities for coordination of benefits and third- party tort liability are explained. This chapter also provides detailed information regarding Health Net's claims processing requirements and reimbursement methods.

Claim Billing Information

In accordance with Medi-Cal law and the Medi-Cal *Provider Participation Agreement (PPA)*, providers have 180 days from the last day of the month of service to submit initial Medi-Cal claims. Providers must contact their participating physician group (PPG) to check for any special billing requirements that the providers' failure to follow could delay the processing of their claims, and to verify the billing address for claims submissions. PPGs must follow the Medi-Cal 180-day timely filing requirements. Exceptions are detailed below.

Exceptions for late filing of new Medi-Cal claims between six months and one year old are permitted without penalty for eligibility status not known, antepartum obstetric care or a delay in delivery of a custom-made prosthesis.

Exceptions for late filing of new claims over one year old are permitted without penalty only for retroactive eligibility situations, court orders, state or administrative hearings, county errors in eligibility, Department of Health Care Services (DHCS) orders, a reversal of appeal decision on a Treatment Authorization Request (TAR), or if other coverage is primary.

ELECTRONIC CLAIMS SUBMISSION

Health Net encourages participating providers to submit claims electronically. Electronic claims from fee-for-service (FFS) providers are submitted to the Health Net Electronic Data Interchange (EDI) Claims Department. An authorized vendor may be used for electronic claim submission. Health Net has contracts with TransUnion Healthcare to provide claims clearinghouse services for Health Net claims submission. Contact the Health Net EDI Claims Department to establish electronic claims submission or for more information.

Coordination of Benefits

Coordination of benefits (COB) is required before submitting claims for members who are covered by one or more health insurers other than Medi-Cal. Medi-Cal is always the payer of last resort, including Medicare and TRICARE.

SUBMISSION OF A COB CLAIM

COB claims must be submitted within 180 days following the date that the provider receives the other coverage's *Explanation of Benefits (EOB)*.

When the provider learns that a Health Net Medi-Cal member has other group health coverage:

- File the provider claim with the primary carrier first.
- After the primary carrier has paid, submit a copy of the explanation of payment or *EOB* with the claim to Health Net or the responsible capitated subcontractor, if one exists.

COB PAYMENT CALCULATIONS

As the payer of last resort, Health Net's Medi-Cal plan coordinates benefits. In order for Health Net to document records and process claims correctly, include the following information on all COB claims:

- Name of the other carrier.
- Subscriber identification (ID) number with the other carrier.

HOW TO BILL MEDI-CAL AFTER BILLING OTHER HEALTH COVERAGE

The provider must present acceptable forms of proof to Health Net that all sources of payment have been exhausted, which may include:

- A denial letter from the other health coverage (OHC) for the service.
- An EOB that shows the service is not covered by the OHC.

DUAL HEALTH NET COVERAGE THROUGH TWO HEALTH NET PLANS

Dual Health Net coverage refers to members that are covered under two Health Net plans. Claims must be submitted to the primary plan first. The Health Net Medi-Cal plan is the secondary coverage under COB rules. The secondary claim must be submitted with the primary Health Net remittance advice, identification and group numbers, indicating the primary Health Net ID number in the Other Coverage box.

Balance Billing and Other Billing Prohibitions

Balance billing is strictly prohibited by state and federal law and Health Net's *PPA*. Balance billing occurs when a participating provider balance bills Medi-Cal beneficiaries for amounts in excess of any Medi-Cal required copayments and deductibles for services covered under a member's benefit program, or for claims for such services denied by Health Net or the affiliated PPG. Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for nonpayment of a claim for covered services. Participating providers agree to accept Health Net's fee for these services as payment in full, except for applicable copayments, coinsurance or deductibles.

Providers are prohibited from charging Medi-Cal members for the completion of any form that is required by, or is necessary for the administration of, the Medi-Cal benefit. This includes, but is not limited to, CMS-1500 and UB-04 claim forms, health histories, patient consent forms, and medical record transfer forms.

Health Net providers are prohibited from charging a Health Net Medi-Cal member for a missed appointment. Medi-Cal managed care members are not share-of-cost beneficiaries and are not subject to copayments or deductibles for office visits, so they cannot be held accountable for these charges in the event of a missed appointment.

Additional information on billing prohibitions is available in the Health Net Medi-Cal provider operations manuals in the Provider Library.

Encounter Submission Requirements

Providers may submit encounters to Health Net through an authorized electronic data interchange (EDI) clearinghouse, utilizing Snip level 1-5. To initiate or discuss the submission of encounter data files, contact the Capitated Claims/Encounter Department.

All professional and institutional encounters must be submitted in an electronic format.

Capitated providers are contractually required to submit complete and correct data for all professional and institutional services performed. Before submitting encounter data, the submitter should contact the Health Net Encounter Department to discuss submission format and data requirements. Health Net currently accepts the ANSI 837 5010 X12 format.

All data should be submitted according to the terms of the Provider Participation Agreement (PPA). If the participating physician group (PPG) does not submit data within this time frame, the PPG is excluded from incentive programs.

Reimbursement Methods

For services provided to Medi-Cal members, Health Net uses reimbursement methods that are based on the DHCS Medi-Cal fee schedule.

Unit values are based on the California 1969 RVS for most services, except laboratory services, which use the California 1974 RVS. Other rates are determined by DHCS or statute and are set out in Title 22 of the California Code of Regulations.

Providers are reimbursed at their contract rates for covered services; however, in cases where a provider contract does not have a rate provision for a specific service, Health Net uses the DHCS Medi-Cal fee schedule rates.

For both participating and nonparticipating providers, Health Net uses reimbursement practices and utilization controls that have been standardized for Medi-Cal services by DHCS. These reimbursement practices include, but are not limited to:

- Certain common office services performed in the outpatient setting of a hospital are reduced by 20%.
- Immunizations and injectable medications, including chemotherapy medications, are paid at statewide flat rates that include the administration fee. Medi-Cal HCPCS codes must be billed for all injectable substances.
- The professional and technical component percentages allowed for outpatient diagnostic services vary depending on the procedure billed.

Medical supplies are paid at statewide flat rates. Medi-Cal HCPCS codes must be billed for all supplies unless otherwise specified in the Medi-Cal Manual as being included in other reimbursed services.

Third-Party Tort Liability

Under Health Net's Medi-Cal contracts, Health Net and its participating providers are prohibited from making any claim for recovery of the value of covered services rendered to a member when such recovery would result from an action involving the tort liability of a third party or recovery from the estates of deceased members or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage.

Health Net and its participating providers are required to assist DHCS in pursuing the state's right to reimbursement from such recoveries. Health Net and its PPGs are required to notify DHCS within 10 days of the discovery of such cases. On request from DHCS for information, Health Net and PPGs must provide additional information within 30 days of the request. Individual providers are obligated to help Health Net and affiliated PPGs provide the additional information on request.

PROVIDER RESPONSIBILITIES

Providers are responsible for the following:

- Notifying Health Net or the PPG in writing of all potential and confirmed third-party tort liability cases involving a Health Net Medi-Cal member.
- Notifying Health Net if the provider receives any requests by subpoena from attorneys, insurers or members for copies of bills.
- Supplying Health Net with copies of the request, copies of documents released as a result of the request, and providing the name, address and phone number of the requesting party. Notifications should be mailed to:

  Health Net TPL
  Recovery TPL Department
  4191 East Commerce Way, Sacramento, CA 95834

In all third-party tort liability cases, bill Health Net or the PPG as usual, and give all details regarding the injury or illness. Health Net pays usual benefits and refers the case to DHCS to pursue recovery.

Timely Claim Processing Requirements

When a member seeks medical attention from a PPG, it is important that the PPG attempts to determine eligibility with Health Net and enrollment in the PPG before providing care. If the PPG does not follow the required steps for verification of eligibility and enrollment, Health Net does not accept financial responsibility for any services performed.

Medi-Cal claims must be processed within 45 business days of receipt. Claims must be submitted within six months of the last date of the month during which services were rendered. Claims submitted beyond this period are denied by Health Net (refer to page 121 for exceptions).

Providers Enrolled in the 340b Program

Health Net requires providers registered and enrolled in the 340B program to include the 340B identifier along with the UD modifier when submitting encounters and claims for physician-administered drugs (PADs). Capitated encounters and fee-for-service (FFS) claims must reflect complete and accurate data in all the required fields using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction, or CMS-1500 and CMS-1450 (UB-04) forms.

Chapter 10 – Grievance and Appeals Procedures

Health Net's grievance and appeals procedures offer recourse to members and providers who are dissatisfied with any aspect of service from Health Net or its participating providers. In receiving and responding to grievances, Health Net does not discriminate on the basis of race, color, national origin, ethnic group identification, ancestry, age, mental disability, physical disability, medical condition, genetic information, religion, sex, marital status, gender, gender identity, or sexual orientation. Likewise, providers shall not discriminate against members in the provision of covered services including without limitation, the filing by members of any grievance against the provider. Members may file grievances anytime about quality of care and may appeal denials of authorizations for services. Providers may also file grievances, appeal for services on the member's behalf, or dispute claim resolution and payment.

This chapter details the procedures for members and providers who wish to file grievances and appeals, matters eligible for appeal and Health Net's policy for resolving complaints.

Member Grievance and Appeal Procedures

MEMBER GRIEVANCE PROCEDURE

A grievance is an oral or written expression of dissatisfaction or concern that does not involve a prior determination. A member, or their physician or other representative, may file a grievance on behalf of the member. Grievance filed by the member's physician or other representative, on behalf of the member, requires written consent from the member or authorized representative. Grievances include, but are not limited to, quality of care concerns, access to care concerns, delay of referral, and other service-related issues, including office wait time, physician behavior and demeanor, adequacy of facilities, and similar concerns. Grievances can also include complaints about involuntary disenrollments. Health Net investigates these complaints and resolves them.

Members are encouraged to attempt to discuss concerns with their provider first. Members have a right to access their medical records. Written authorization from the member or the member's authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by Health Net. Resolutions of grievances that involve a provider are confidential and protected from disclosure by law. A member cannot be discriminated against for filing a grievance.

Members may submit grievances verbally or in writing. To submit a grievance in writing, members may contact the Health Net Medi-Cal Appeals and Grievance Department. To submit a verbal grievance, members may contact the Health Net Medi-Cal Member Services Department. Los Angeles County members affiliated with Molina may also submit grievances to their respective affiliated plan.

Members may obtain a Member Grievance/Complaint form from their provider's office. Members may also contact the Health Net Medi-Cal Member Services Department for assistance with filing the grievance.

Once the Health Net Medi-Cal Appeals and Grievance Department receives the member grievance, it is sent to a grievance coordinator for investigation. Health Net provides the member with a written acknowledgment of the grievance within five calendar days of receipt. The member is informed in writing of the grievance resolution within 30 calendar days. If a grievance cannot be resolved within 30 calendar days, a letter of explanation that includes the reason for the delay and an estimated date of resolution is sent to the member.

If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved, or a grievance that has remained unresolved for more than 30 days, the member may call the Health Net Medi-Cal Appeals and Grievances Department for assistance.

Members may also request an expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major

bodily function. The member is informed in writing of the expedited grievance resolution within 72 hours.

MEMBER APPEAL PROCEDURE

A member appeal is a request for reconsideration of an adverse benefit determination which is communicated in the form of a Notice of Action (NOA). Member appeals may be submitted in response to a NOA by the member, or the provider on the member's behalf, verbally or in writing, within 60 calendar days of the date on the NOA to the Health Net Medi-Cal Member Appeals and Grievance Department. Appeals received after the 60-day time frame are not considered. Upon request, Medi-Cal Member Services Department representatives are available to assist members in writing an appeal. An appeal must include any additional or supporting information the member would like Health Net to consider.

APPEAL RESOLUTION PROCESS

When the Health Net Medi-Cal Member Appeals and Grievance Department receives the appeal, it is assigned a case number, researched and resolved. A written acknowledgment is mailed to the member within five calendar days of receipt of the written appeal. Within 30 days of receipt of a standard appeal, and with 72 hours of receipt of an expedited appeal; members are sent a written Notice of Appeal Resolution (NAR), stating the decision made and the rationale for that decision.

If Health Net upholds the initial denial of coverage, the member has the following options:

- Member may apply to the DMHC for an Independent Medical Review (IMR) within 180 days from the date of the NAR letter or after exhausting the plan's grievance and appeals process. However, the member may request an Independent Medical Review (IMR) from the DMHC right away if the member's health is in immediate danger or if the request was denied because treatment is considered experimental or investigational; otherwise, the member must first file an appeal with the plan.
- The member may request a state hearing online, by phone or in writing from the California Department of Social Services (DSS) only after receiving an NAR and within 120 calendar days from the date of the NAR letter. Members may continue to receive benefits during the hearing process, and have the right to representation by legal counsel, a friend or other spokesperson during the process.

  Members can ask for a State Hearing in the following ways:

  - Online at www.cdss.ca.gov
  - By phone: 800-743-8525/TTY/TDD 800-952-8349.
  - In writing: Members should fill out a State Hearing form or write a letter. Send it by mail or fax to:

    Mail: California Department of Social Services
    State Hearings Division
    P.O. Box 944243, Mail Station 9-17-37
    Sacramento, CA 94244-2430
    Fax: 916-309-3487 or toll-free at 833-281-0903

PROVIDER-INITIATED MEMBER APPEALS

A provider or an authorized representative may submit an appeal on behalf of the member when the member is challenging a denial for a prior authorization request or a service. Appeals filed by the provider or authorized representative, on behalf of the member, require written consent from the member or authorized representative. Members have a right to access their medical records. Written authorization from the member or the member's authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by Health Net.

These appeals are considered member appeals, not provider appeals. They are processed in the same manner as an appeal submitted by a member:

- Health Net processes the appeal, not the PPG or subcontractor.
- Health Net's decision is final. There is no second-level appeal between Health Net and the PPG.
- Providers do not have the option of requesting a fair hearing with DSS.

MEMBER APPEALS ADDRESS

Health Net Medi-Cal Member Appeals and Grievances
Department PO Box 10348
Van Nuys, CA 91410-0348

Provider Grievance Procedure

A provider grievance is a verbal or written expression of dissatisfaction or concern that does not involve a prior determination. Provider grievances include quality of care concerns, access to care concerns, complaints regarding delays of referrals or authorizations, patient dumping issues, and provider refusals to submit medical records. There are two types of provider grievances:

- Administrative – concerns of a non-clinical nature.
- Clinical – concerns of a clinical nature.

Provider grievances may be submitted verbally or in writing within 180 days of the date of occurrence. The first step in registering a grievance is to call the Health Net Medi-Cal Provider Services Department.

The second step is to submit it in writing with the following information:

- A description of the problem, including all relevant facts.
- Names of involved people.
- Date of occurrence.
- Supporting documentation.

Health Net participating providers are notified in writing of receipt of a grievance within five business days. A grievance received without all required information is returned to the submitting provider with instructions for resubmitting the grievance with the missing information. The provider must resubmit the completed grievance within 30 business days of receipt of the request for additional information.

Providers are informed in writing of resolution of the grievance within 30 business days. If resolution of the case exceeds 30 business days, Health Net will send the provider a letter of explanation by the 30th business day documenting the reason for the delay and an estimated completion date for the resolution.

RESOLUTION PROCESS

A Health Net Medi-Cal Provider Services representative who receives the grievance forwards the information to a Health Net Medical Review Unit case coordinator. The case coordinator handles the grievance and corresponds with the provider, including requesting any additional information necessary. Upon receipt of all necessary information, the case coordinator forwards the grievance to the Health Net regional medical director responsible for the region for review and resolution of the grievance.

The Health Net regional medical director reviews all provider grievances. The medical director evaluates the grievance using multiple resources, criteria and guideline sets that include:

- Title 22, California Code of Regulations.

- Electronic Data Systems (EDS) Medi-Cal Provider Manual guidelines.
- Department of Health Care Services (DHCS) Manual of Criteria.
- Current Procedural Terminology (CPT) guidelines.
- InterQual® Criteria sets.
- Hospital Chargemaster Guide (Ingenix).
- Health Net Medi-Cal Claims policies and procedures.

Upon completion of the medical director review and determination, the case is returned to the case coordinator who then notifies the provider in writing of the determination, the reason for the determination, actions taken, and a description of the provider's options if the provider is dissatisfied with the outcome.

Information gathered by Health Net, and as a result of review of quality-related grievances that involve a provider, is considered confidential and protected from disclosure as quality of care-related peer review activities under California law. Provider grievances related to a request for reassignment or disenrollment of a Medi-Cal member are referred to the Health Net Medi-Cal Member Services Department.

PEER-TO-PEER REVIEW REQUESTS

The Plan aims to promote treatment that is specific to the member's condition and consistent with medical necessity, clinical practice, and appropriate level of care. An authorization request will be denied if the information provided does not meet the coverage requirements for the requested medical treatment. The Plan will notify the provider and the member of the reason for the adverse determination.

Providers may contact the Plan to discuss the adverse determination with a medical director (known as peer-to-peer review or P2P) using the instructions below.

Peer-to-peer reviews may not be used in certain situations. The peer-to-peer review does not apply to:

- Appeals. Once you or a member submit an appeal, you cannot request a peer-to-peer review. If the member submits the appeal for an adverse determination you have issued, we will reach out to you for any additional information you may have.
- Post-discharge. For adverse concurrent review determinations, you must request a peer-to-peer review prior to the member's discharge. Once the member has been discharged from a facility, you cannot request a peer-to-peer review. If a member is discharged on the weekend, please call prior to discharge and leave a message for your peer-to-peer request to be considered timely. Beyond this time, an appeal may be filed.
- Initial adverse determinations beyond five business days. You have five business days to request a peer-to-peer review following issuance of an adverse prior authorization determination. Beyond this time, an appeal may be filed.

Contact the Peer-to-Peer Review Request Line at 818-676-5503 with the necessary information available to request a peer-to-peer review. If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Provider Dispute and Appeal Procedures

Health Net's provider dispute resolution process ensures correct routing and timely consideration of provider disputes or appeals. Participating providers use this process to:

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net.
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in

order to process the claim.

- Challenge a request by Health Net for reimbursement for an overpayment of a claim.
- Seek resolution of a billing determination or other contractual dispute with Health Net.
- Appeal a PPG's written determination following its dispute resolution process when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of Health Net's or PPG's written determination.

Additional processes depending on the provider's contractual relationship with Health Net include challenging:

- Capitated PPG or hospital liability for medical services and payment that are the result of Health Net decisions arising from member grievances, appeals and other member services actions.
- Capitation deductions that are the result of Health Net decisions arising from member billings, claims or member eligibility determinations.

Health Net does not charge providers of service who submit disputes to the Health Net Medi-Cal Appeals Unit for processing provider disputes and does not discriminate or retaliate against a provider who uses the provider dispute process. Further, providers participating through a Health Net PPG cannot be charged a processing fee when utilizing the PPG's provider dispute process.

Disputes regarding the denial of a referral or a prior authorization request are considered member appeals. Although providers may appeal on a member's behalf, the member appeal process must be followed (refer to page 126, Member Appeal Procedure for more information).

SUBMISSION OF PROVIDER DISPUTES

Health Net accepts disputes, including appeals, from participating providers if they are submitted within 365 days of receipt of Health Net's decision (for example, denial or adjustment), except as described below. If the provider does not receive a decision from Health Net, the dispute must be submitted within 365 days after the deadline for contesting or denying the claim has expired. If the provider's *Provider Participation Agreement (PPA)* provides for a dispute-filing deadline that is greater than 365 calendar days, this longer time frame will continue to apply until the contract is amended.

When submitting a provider dispute, a provider must use the Provider Dispute Resolution Request Form, available in the Health Net Medi-Cal Provider Library. If the dispute is for multiple, substantially similar claims, the Provider Dispute Resolution Request Spreadsheet (page two of Request Form) must be submitted with the Provider Dispute Resolution Request Form. The provider dispute must include:

- Provider's name, identification (ID) number, contact information, including phone number, and the original claim number.
- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include a clear identification of the disputed item; the date of service; and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is not about a claim, the provider must include a clear explanation of the reason for the dispute, including, if applicable, relevant references to the *PPA*.

Providers who participate under a capitated agreement with a PPG must submit disputes to the PPG that processed the claim.

DISPUTES SUBMISSION ADDRESSES

Provider disputes concerning a medical claim should be submitted as indicated below.

Capitated Provider First-Level Disputes
These must be sent to the PPG or subcontracting health plan claims billing address.

FFS Providers and Capitated Provider Second-Level Disputes
Health Net Medi-Cal Provider Appeals Unit
PO Box 989881
West Sacramento, CA 95798-9881

ACKNOWLEDGMENT AND RESOLUTION

Health Net acknowledges receipt of each provider dispute in writing and within 15 business days of receipt.

If the provider dispute submission does not include all pertinent details of the dispute, it is returned to the provider with a request detailing the additional information required to resolve the issue. The amended dispute must be submitted with the missing information within 30 business days from the date of receipt of the request for additional information.

Providers are not asked to resubmit claim information or supporting documentation that was previously submitted to Health Net as part of the claims adjudication process, unless Health Net returned the information to the provider.

Health Net resolves each provider dispute within 45 business days following receipt and sends the provider a written determination stating the reasons for the determination.

Participating providers who contract directly with Health Net and disagree with Health Net's determination may refer to their *PPA* for other available resolution mechanisms.

PROVIDER INQUIRY PROCESS

In addition to the provider dispute process, a provider inquiry process is available for routine claim follow-up when a participating provider wants to:

- Inquire about the status of a claim or to obtain payment calculation clarification.
- Resubmit contested claims with the missing information requested by Health Net.
- Submit a corrected claim (additional charges previously not submitted).
- Clarify member responsibility.

SUBMISSION OF PROVIDER INQUIRIES

For routine claim follow-up, providers may contact Health Net Provider Services Department. Providers may use the following claims addresses for resubmission of contested claims with missing information (requested individual claim documents), submission of corrected claims (additional charges previously not submitted), submission of a new claim, or submission of provider appeals.

Health Net New Medi-Cal Claims Submission
PO Box 9020 Farmington, MO 63640-9020

Health Net Medi-Cal Contested/ Corrected Claims Submission
PO Box 989736 West Sacramento, CA 95798-9881

Health Net Medi-Cal Provider Appeal Submissions
PO Box 989881 West Sacramento, CA 95798-9881

Providers may use their own spreadsheet or form when submitting provider inquiry requests to the Health Net Medi-Cal Provider Services Department. Providers must include the following information on their spreadsheet or form to

ensure appropriate research:

- Provider Full Name
- Provider Tax ID or NPI number
- Member's name
- Member's date of birth (DOB)
- Health Net identification (ID) Card number
- Date of service
- Billed amount
- Claim number

Providers who participate in Health Net's Medi-Cal plan under a capitated PPG must submit inquiries to the PPG or affiliated health plan.

For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. For Molina Healthcare Provider Services Department please contact Molina directly.

Address: 200 Oceangate, Ste. 100 Long Beach, CA 90802
Phone Number: 855-322-4075
Fax: 855-278-0312
www.molinahealthcare.com

REQUESTS

If a participating provider believes that a claim was processed inaccurately and wants to request an adjustment, the claim may be resubmitted to Health Net requesting reconsiderations of the claim by following the provider dispute resolution process.

APPEAL STATUS

Providers can contact the Health Net Medi-Cal Provider Services Department or Health Net Medi-Cal Member Services Department to check the status of a dispute or appeal.

PROVIDER ENCOUNTER SUPPLEMENTAL DISPUTE PROCEDURES

The provider encounter supplemental payment dispute resolution process ensures correct routing and timely consideration of provider encounter supplemental payment disputes. Both participating and non-participating providers use this process to:

- Dispute, challenge or request reconsideration of an encounter (including a bundled group of similar encounters) that has or has not been paid by the health plan supplemental add-on amount allowed by DHCS for DHCS Directed Payments Programs.
- Challenge a request by the health plan for reimbursement for an overpayment of an encounter supplemental add-on payment.

Health Net does not charge providers of service who submit disputes to the Health Net Direct Pay Encounter Department for processing provider disputes and does not discriminate or retaliate against a provider who uses the provider dispute process.

PROVIDER ENCOUNTER SUPPLEMENTAL PAYMENT DISPUTES SUBMISSION

Health Net accepts encounter supplemental payment disputes from participating and non-participating providers if they are submitted within 365 days of receipt of the health plan's supplemental payment, except as described below. If the provider does not receive a supplemental payment from the Health Net, the dispute must be

submitted within 365 days of Health Net's receipt of the encounter. If a participating provider's Provider Participation Agreement (PPA) provides for a dispute-filing deadline that is greater than 365 calendar days, this longer time frame will continue to apply until the contract is amended.

When submitting a provider encounter supplemental payment dispute, a provider must submit the dispute electronically to the Direct Pay Encounter Department disputes email at HNCA_EncDisputes@healthnet.com.

The provider dispute must include at minimum:

- The reason for the dispute.
- Impacted tax ID number(s) and NPI(s).
- Member level detail via Excel spreadsheet including:
  - Patient name(s).
  - Date of birth.
  - CIN ID(s).
  - Dates of service.
  - CPT/HCPC(s) submitted along with any modifiers.
  - Patient control number/PPG claim number.

ACKNOWLEDGMENT AND RESOLUTION

Health Net acknowledges receipt of each provider encounter supplemental payment dispute received electronically via email within two business days of receipt.

If the provider encounter supplemental payment dispute submission does not include all pertinent details of the dispute, it is returned to the provider with a request detailing the additional information required to resolve the issue. The amended dispute must be submitted with the missing information within 30 business days from the date of receipt of the request for additional information.

Health Net resolves each provider dispute within 45 business days following receipt and sends the provider an electronic determination stating the reasons for the determination.

Glossary

Appeal. Also known as a dispute, a request for reconsideration of an initial determination for prior authorization of a service, or for the denial or adjustment of a claim.

Authorization. Approval requested and obtained by providers for designated service before the service is rendered. Used interchangeably with prior authorization.

Beneficiary Identification Card (BIC). A plastic card issued by the state to recipients of entitlement programs, which is used by contractors to verify health plan eligibility. Eligibility files are updated monthly.

California Children's Services (CCS). A state and county program providing medically necessary specialized medical care and rehabilitation to those under age 21 with physically handicapping conditions defined in Medi-Cal law, and who meet medical, financial and residential eligibility requirements for the CCS program.

California Work Opportunities and Responsibility to Kids (CalWORKs). A state program that provides temporary financial assistance and employment-focused services to families with minor children who have income and property below state maximum limits for their family size.

Department of Mental Health (DMH). The state agency that sets policy and administers the delivery of community- based public mental health services statewide.

Department of Health Care Services (DHCS). The state agency responsible for administration of the Medi-Cal, Comprehensive Perinatal Services Program (CPSP), CCS, and other health-related programs.

Drug Medi-Cal Program Services (D/MC). The program administered by the California Department of Mental Health to provide medically necessary drug abuse services to Medi-Cal beneficiaries who meet the eligibility criteria defined in Medi-Cal law. Services include assessment, crisis intervention, group and individual counseling, naltrexone treatment services, perinatal residential drug abuse services, outpatient methadone maintenance services, and day care rehabilitative services.

Eligible Beneficiary. Any Medi-Cal beneficiary residing in the service area of a Medi-Cal contractor and who qualifies for one of the following categories (with a specific aid code): CalWORKs, Medically Needy Family, Seniors and Persons with Disabilities (SPD) population, Medically Indigent Child, Medically Indigent Adult, and Refugee.

Emergency Care. The provision of medically necessary services required for the immediate alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Lack of such care could lead to disability or permanent damage to the patient's health if not diagnosed and treated without delay.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens Program. An initial, periodic or additional health assessment of an eligible individual under age 21 is provided in accordance with Medi-Cal law. The program consists of periodic and interperiodic screening services, and diagnostic and treatment services, including care management services.

Fee-for-Service (FFS). A method of charging based upon billing for a specific number of units of services rendered to an eligible beneficiary. FFS is the traditional method of reimbursement used by physicians, and payment almost always occurs retrospectively.

Grievance. An expression of dissatisfaction regarding access to care or quality of care problems by a member or provider.

Health Maintenance Organization (HMO). An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed-upon set of comprehensive health maintenance and treatment services for an enrolled group through a predetermined periodic fixed prepayment.

Indian Health Service (IHS) Facilities. Facilities operated with funds from the IHS under the Indian Self-

Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

Medical Records. A confidential document containing written documentation related to the provision of physical, social and mental health services to a patient.

Medically Necessary. Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member. An eligible beneficiary who has enrolled in a Health Net plan.

Newborn Child. A newborn child is covered for the month of birth and the following month when delivered of a mother during her membership or in the month prior to her membership.

Participating Physician Group (PPG). Health Net may contract with individual physicians through a global contract with the physicians' contracting medical groups or independent practice associations (IPAs). This is called a participating physician group, also known as a subcontractor.

Participating Provider. A facility, physician, physician organization, other health care provider, supplier, or other organization, which has met applicable credentialing and/or recredentialing requirements, if any, and has, or is governed by, an effective agreement directly with Health Net, or indirectly through another entity, such as another participating provider, to provide covered services.

Preventive and Screening Services for Children and Youth Under Age 21. Preventive care screening program for eligible beneficiaries under age 21 as provided in Medi-Cal law. Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens Supplemental Services and the Prenatal Guidance Program.

Preventive Care. Health care designed to prevent disease and its consequences. There are three levels of preventive care: primary, such as immunizations aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy aimed at restoring function after disease has occurred.

Primary Care. A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level providers. This type of care emphasizes caring for the member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Physician (PCP). A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP has focused the delivery of medicine to general practice or is a board-certified or board-eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner.

Quality Assurance (QA). A formal set of activities to assure the quality of clinical and non-clinical services are provided. QA includes quality assessment and corrective actions taken to remedy any deficiencies identified

through the assessment process.

Referral. The practice of sending a patient to another participating provider for services or consultation that the referring provider is not prepared or qualified to render.

Sensitive Services. The following services are considered sensitive: sexual assault, drug or alcohol abuse, pregnancy, family planning, pregnancy termination, mental health, and sexually transmitted infections designated by the director of DHCS for children ages 12 or older.

Urgent Care. Medically necessary services provided for an unforeseen illness or injury required to prevent the serious deterioration of health. Treatment of the illness or injury requires professional attention that cannot be delayed for longer than 48 hours, or disability or permanent damage to the patient's health could result.

Utilization Management (UM). A formal, prospective, concurrent, or retrospective critical examination of appropriate use of segments of the health care system, such as hospitalization, clinics, provider services, emergency departments, skilled nursing facilities, and home care.

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