

Medi-Cal 2018 Operations *Guide*



Introduction

The Medi-Cal Operations Guide is a summary of the Medi-Cal county-specific provider manuals that are available in the Provider Library on the 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 the 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 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.

For detailed county-specific information, consult the Medi-Cal provider operations manuals for each county.

Contractual Arrangements and Applicability to Fresno, Kings and Madera Counties

CalViva Health is the local initiative health plan for Medi-Cal managed care in Fresno, Kings and Madera counties. CalViva Health is a full-service health plan contracting with the Department of Health Care Services (DHCS) to provide services to Medi-Cal managed care enrollees under the Two-Plan model in all ZIP codes in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net to provide certain administrative and health care services to CalViva Health members on CalViva's behalf.

Health Net continues to hold most provider contracts in Fresno, Kings and Madera counties as CalViva Health's subcontractor.

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.

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Glossary

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Who to Contact

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

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

Public Programs Department

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

The Public Programs Department includes two teams. The Public Programs County Relations team establishes and maintains positive relations with county programs and its affiliated community service providers in working with the following departments: local County Public Health, Behavioral Health, Substance Use Disorder, Regional Centers and school-based health centers. The Public Programs Transactional/Operations team helps with resolving access to care issues, care coordination issues and work with managed Long-Term Services and Support programs.

Provider Relations Department

The Provider Relations Department primarily provides support, education and training to the Medi-Cal providers in the plan's 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 Center

Medi-Cal Provider Services Center representatives are available 24 hours a day, seven days a week, 365 days a year to assist providers with member eligibility, primary care physician (PCP) selection and transfer requests, 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. Members and providers may request an interpreter by calling 1-888-893-1569.

Member Resources

Health Education Department

The Health Education Department educates 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, classes, and other information in various threshold languages.

Cultural and Linguistic Services Department

The Cultural and Linguistic (C&L) Services Department promotes access to care for members who speak a primary language other than English. The department is responsible for developing, implementing and monitoring processes to meet regulatory requirements. The department assesses the cultural and language needs of members and encourages provider, community advocate, and member input through ongoing communication and by participation in the CalViva Health Public Policy Committee. This helps ensure that materials and interpreter services are available in the member's language, while taking into consideration the member's cultural background in the development of member materials.

Medi-Cal Member Services Department

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

Telephone Numbers and Addresses

CalViva Health Administration

CalViva Health Administration is the primary administrative office of CalViva Health and the Fresno-Kings-Madera Regional Health Authority.

7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

(559) 540-7840

Fax: (559) 466-1990

Compliance and Medical Management

Fax: (559) 446-1998

Communications

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

provider.communications@healthnet.com

Fax: 1-800-937-6086

Credentialing

The Credentialing Department is responsible for credentialing and recredentialing directly contracting providers and all providers affiliated with PPGs to which credentialing responsibilities have not been delegated. The Credentialing Department also oversees delegated and subcontracting credentialing activity.

1-888-893-1569

Cultural and Linguistic Services

The C&L Services 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

1-800-977-6750

Fax: (818) 543-9188

Delegation Oversight

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

Fax: 1-866-476-0311

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 the health plan's Medi-Cal contracts.

1-800-322-6384

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.

1-888-452-8609

Department of Managed Health Care

The Department of Managed Health Care (DMHC) licenses and 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.

1-888-466-2219

Department of Social Services

The Department of Social Services (DSS) Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding hearings and grievances.

PO Box 944243, Sacramento, CA 94244-2430

1-800-952-5253

Electronic Data Interchange (EDI) Claims

Participating providers are required to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse (TransUnion Healthcare). All other questions regarding electronic claims submission should be directed to the EDI Department.

1-800-977-3568

Eligibility Verification

The Medi-Cal Provider Services Center verifies member eligibility 24 hours a day, seven days a week, 365 days a year. Eligibility can also be verified online at www.healthnet.com.

1-888-893-1569

Encounters

Contact the 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.

1-800-977-3565

Health Care Options

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

Arabic

1-800-576-6881

Armenian

1-800-840-5032

Cambodian

1-800-430-5005

Cantonese

1-800-430-6006

English and other languages

1-800-430-4263

Farsi

1-800-840-5034

Hmong

1-800-430-2022

Korean

1-800-576-6883

Laotian

1-800-430-4091

Mandarin

1-800-576-6885

Russian

1-800-430-7007

Spanish

1-800-430-3003

Tagalog

1-800-576-6890

Vietnamese

1-800-430-8008

TTY/TDD (hearing impaired)

1-800-430-7077

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 telephone or fax to request elective and urgent services.

Prior Authorization

1-800-421-8578

Fax: 1-800-743-1655

Health Net Pharmacy Benefit Manager

Health Net's pharmacy benefit manager (PBM) administers CalViva Health's formulary and medication prior authorization requests.

PO Box 419069, Rancho Cordova, CA 95741

1-800-867-6564

Fax: 1-800-977-8226

Hospital Notification Unit

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

1-800-995-7890

Fax: 1-800-676-7969

Interpreter Services

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

1-888-893-1569

Medi-Cal Claims

Send written correspondence, claims, tracers, adjustment requests, or denial reconsiderations to 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 telephone and written inquiries from members regarding claims, benefits, eligibility, identification, grievances, disputes and appeals, or selecting PCPs.

21281 Burbank Blvd. C-5, Woodland Hills, CA 91367

1-888-893-1569

Fax: (818) 676-5387

Medi-Cal Provider Appeals Unit

Submit claims appeals to Medi-Cal Claims Appeals at the following address:

PO Box 419086, Rancho Cordova, CA 95741-9086

Medi-Cal Provider Services Center

The Provider Services Center handles telephone and written inquiries from providers regarding claims, benefits, and provider grievances and appeals.

21281 Burbank Blvd. C-5, Woodland Hills, CA 91367

1-888-893-1569

Fax: 1-800-281-2999

Fax: (818) 676-5387

Email:***Eligibility and billing inquiries***

hnmedi-cal.eligibility@healthnet.com

Claim status and denial inquiries

hnmedi-cal.claimsinqury@healthnet.com

Capitated claims/non-payment

hnmedi-cal.providerbilling@healthnet.com

MHN Customer Service Department

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 the MHN Customer Service Department for a referral to an MHN provider.

1-888-935-5966

Nurse Advice Line

The nurse advice line is staffed after business hours by registered nurses for member assistance and referral.

1-888-893-1569

Quality Improvement

Contact the Quality Improvement Department for information about quality improvement projects for the health plan's Medi-Cal members.

Cqi_dsm@healthnet.com

Website Resources

The Health Net website offers information about CalViva Health member eligibility, claim status, contact information and reference materials, members' *Evidence of Coverage*, and county-specific Medi-Cal operations manuals and forms.

provider.healthnet.com

CalViva Health's website offers additional information, such as CalViva Health's *RDL* and other reference materials.

www.calvivahealth.org

Fresno County

Provider Relations

The Provider Relations Department provides support, education and training to the plan'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: 1-877-779-0753

Facility.site.review@healthnet.com

Health Education

The Health Education Department improves the health of Medi-Cal members through education, information and member support.

7625 N. Palm Ave., Ste. 101, Fresno, CA 93711

1-800-804-6074

Fax: 1-800-628-2704

Provider Network Management

The Provider Network Management Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

(559) 447-6137

Fax: (559) 447-6170

Public Programs Coordination

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

1-800-526-1898

Public Health Agencies

California Children's Services (CCS)

County Department of Health, California Children's Services (CCS)

1221 Fulton Mall, Fresno, CA 93721

(559) 600-3300

Fax: (559) 455-4789

Child Health and Disability Prevention (CHDP) Program

County Department of Health, Community Health Department

1221 Fulton Mall, Fresno, CA 93721

(559) 600-3281

Fax: (559) 600-7726

Communicable Disease Investigation Program

County Department of Health, Communicable Disease Control

1221 Fulton Mall, Fresno, CA 93721

(559) 600-3332

Fax: (559) 600-7607

Community-Based Adult Services Centers

Adult Day Health Care of Fresno and Clovis

5757 N. First St., Fresno, CA 93710

(559) 227-8600

Fax: (559) 227-8200

Heritage Adult Day Health Care Center

5377 N. Fresno St., Fresno, CA 93710

(559) 222-0304

Fax: (559) 222-2132

Heritage West Adult Day Health Care Center, LLC

3677 W. Beechwood Ave., Fresno, CA 93711

(559) 261-0707

Fax: (559) 261-9995

Comprehensive Perinatal Services Program (CPSP)

MCH Program

County Department of Health, Community Health Department

1221 Fulton Mall, Fresno, CA 93721

(559) 600-3330

County Mental Health Plan

4441 E. Kings Canyon, Fresno, CA 93702

(559) 600-9180

1-800-654-3937

Multipurpose Senior Services Program (MSSP)

Fresno-Madera Agency on Aging Direct Services Division

3837 N. Clark St., Fresno, CA 93726

(559) 600-4405

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)

Fresno Economic Opportunity Commission

(559) 263-1150

Huron WIC Clinic

(559) 945-5090

Kerman WIC Clinic

(559) 846-6681

Mendota WIC Clinic

(559) 655-6820

Orange Grove WIC Clinic

(559) 626-5030

Parlier WIC Clinic

(559) 646-6611

Reedley WIC Clinic

1-888-638-7177

Sanger WIC Clinic

(559) 875-8639

Selma WIC Clinic

(559) 891-7097

Substance Abuse

(559) 600-6087

Kings County

Provider Relations

The Provider Relations Department provides support, education and training to the plan'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: 1-877-779-0753

Facility.site.review@healthnet.com

Health Education

The Health Education Department improves the health of Medi-Cal members through education, information and member support.

7625 N. Palm Ave., Ste. 101, Fresno, CA 93711

1-800-804-6074

Fax: 1-800-628-2704

Provider Network Management

The Provider Network Management Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

(559) 447-6137

Fax: (559) 447-6170

Public Programs

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

1-800-526-1898

Public Health Agencies

AIDS Waiver Program

*Kings County Department of Public Health
Division of Nursing and Community Services*

330 Campus Dr., Hanford, CA 93230

(559) 584-1401

Fax: (559) 589-0652

California Children's Services (CCS)

330 Campus Dr., Hanford, CA 93230

(559) 852-4693

Fax: (559) 582-6803

Child Health and Disability Prevention (CHDP) Program

330 Campus Dr., Hanford, CA 93230

(559) 584-1401

Fax: (559) 584-5672

Communicable Disease Reporting

Kings County Department of Public Health

Communicable Disease Services

330 Campus Dr., Hanford, CA 93230

(559) 584-1401

Fax: (559) 584-5672

Comprehensive Perinatal Services Program (CPSP)

330 Campus Dr., Hanford, CA 93230

(559) 584-1401

Fax: (559) 584-5672

County Mental Health Plan

Kings County Behavioral Health

450 Kings County Dr., Ste. 104, Hanford, CA 93230

(559) 582-3211, ext. 2376

Multipurpose Senior Services Program (MSSP)

Kings-Tulare Area Agency on Aging

4031 W. Noble Ave., Visalia, CA 93277

(559) 623-0199

1-800-321-2462

Regional Center

Central Valley Regional Center

5441 W. Cypress Ave., Visalia, CA 93277

(559) 738-2200

Fax: (559) 738-2265

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

Hanford, Lemoore, Avenal, Corcoran, Kettleman

(559) 582-0180

Substance Abuse

Kings County Behavioral Health

330 Campus Dr., Hanford, CA 93230

(559) 584-1401

TB Control Program

Kings County Department of Public Health

Communicable Disease Services

Tuberculosis Control Program

330 Campus Dr., Hanford, CA 93230

(559) 584-1401, ext. 2741

Madera County

Provider Relations

The Provider Relations Department provides support, education and training to the plan'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: 1-877-779-0753

Facility.site.review@healthnet.com

Health Education

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7625 N. Palm Ave., Ste. 101, Fresno, CA 93711

1-800-804-6074

Fax: 1-800-628-2704

Provider Network Management

The Provider Network Management Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

(559) 447-6137

Fax: (559) 447-6170

Public Programs

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

1-800-526-1898

Public Health Agencies

AIDS Waiver Programs

Madera County Department of Public Health

14215 Rd. 28, Madera, CA 93638

(559) 675-7893

Fax: (559) 674-7262

California Children's Services (CCS) Program

Madera County Department of Public Health

14215 Rd. 28, Madera, CA 93638

(559) 675-4945

Fax: (559) 675-7803

Child Health and Disability Prevention (CHDP) Program

Madera County Department of Public Health

14215 Rd. 28, Madera, CA 93638

(559) 675-7893

Fax: (559) 675-7803

Communicable Disease Reporting

Madera County Department of Public Health

Communicable Disease Control Program

14215 Rd. 28, Madera, CA 93638

(559) 675-7893

Fax: (559) 674-7262

Comprehensive Perinatal Services Program (CPSP)

Madera County Department of Public Health

14215 Rd. 28, Madera, CA 93638

(559) 675-7893

Fax: (559) 674-7867

County Mental Health Plan

Madera County Behavioral Health Services

117 N. R St., Madera, CA 93637

(559) 675-7926

1-888-275-9779

Fax: (559) 661-2818

Multipurpose Senior Services Program (MSSP)

Fresno-Madera Agency on Aging Direct Services Division

3837 N. Clark St., Fresno, CA 93726

(559) 600-4405

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)

Madera

(559) 675-7623

Oakhurst

(559) 658-7456

Chowchilla

(559) 201-5000

Substance Abuse

Madera County Behavioral Health Services

209 E. 7th St., Madera, CA 93638

(559) 673-3508

TB Control Program

Madera County Public Health Department

Communicable Disease Control Program

Tuberculosis Control Program

14215 Rd. 28, Madera, CA 93638

(559) 675-7893

Fax: (559) 674-7262

Chapter 2 – Enrollment and Disenrollment

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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.
- 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 sub-acute, 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:
 - » AIDS 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 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 about 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 Medi-Cal beneficiaries who do not make a choice at an HCO enrollment contractor presentation. 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 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.

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 automatically assigns a PCP.

PCP Selection Criteria

The Medi-Cal Member Services Department is available to assist members with their selection of a PCP. Provider directories listing PCP office locations, language capabilities and telephone numbers are also available for member use.

If a member does not select a PCP at the time of enrollment, the health plan assigns one to allow member access to medical care immediately upon enrollment.

The following assignment process is used:

- In auto-assigning a PCP, the system searches for a PCP within 10 miles or 30 minutes of the member’s residence.
- The health plan considers the language preference of the member. The system searches for a PCP who is fluent in the member’s preferred language or who has staff fluent in the member’s spoken language.

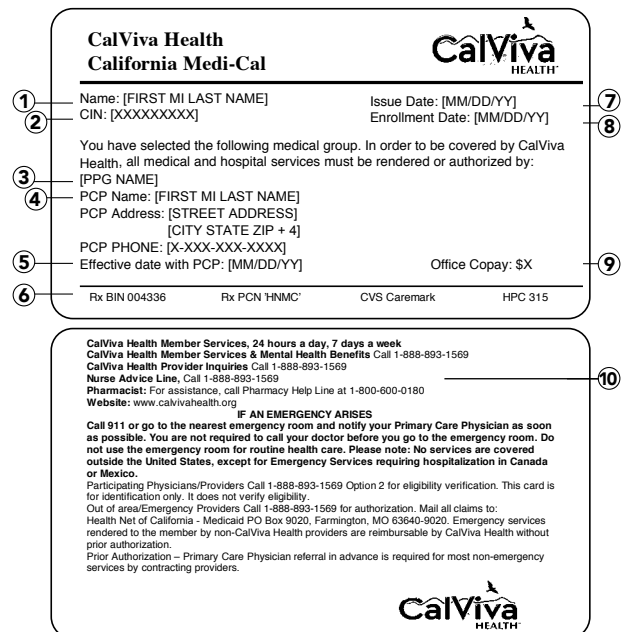
The health plan also considers families. Family members over age 14 are assigned to the same PCP to help make appointment scheduling easier for the family. Children ages 14 and younger are assigned to a pediatrician if one is available who meets the geographic and language preference criteria. All such children in a family are assigned to the same pediatrician.

Identification Card and Member Material Distribution

The health plan 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

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 telephone 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. Pharmacy Information – Contact and claims information for prescription medication processing vendor
7. Issue Date – Date the ID card was issued
8. Enrollment Date – Date the member was enrolled with Health Net Medi-Cal
9. Copayments – Out-of-pocket expense the member is required to pay for covered services (varies by plan)
10. Important Telephone Numbers – Health Net contact telephone numbers



Member Identification Number

The health plan uses the client index numbers (CINs), issued by DHCS, as the ID numbers for all 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 issues 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 enrolls 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.

The disenrollment process may take 15 to 45 days to complete. During this time, the health plan continues to be responsible for the member's health care. DHCS, not the plan, processes all disenrollment requests.

Disenrollment is mandatory under the following conditions:

- Enrollee loses Medi-Cal eligibility.
- Enrollee moves out of the plan's approved service area.
- Enrollee's Medi-Cal aid code changes to an aid code not covered under the health plan.
- Enrollee's enrollment violated state marketing and enrollment law.
- Enrollee requests disenrollment as a result of a plan merger or reorganization.
- Enrollee is eligible for certain carve-out or waiver programs that require disenrollment (for example, long-term care for the month of admission and the following month, major organ transplants with the exception of adult kidney transplants, and certain waiver programs).

Provider Requests to Disenroll a Member

To request disenrollment of a member, participating providers must contact the Medi-Cal Member Services Department, which asks the provider to describe the circumstances and submit documentation for the request.

On notification, the Medi-Cal Member Services Department contacts the member and provides counseling. If necessary, the department reassigns the member to a new PCP within the health plan.

Failure to follow prescribed treatment, including failure to keep appointments, is not, in itself, good cause for disenrollment, unless the health plan and participating provider can demonstrate to DHCS that, as a result of such failure, the health plan or provider is exposed to a great risk.

If a member refuses to transfer from an out-of-network hospital to an in-network hospital when it is medically safe to do so, a temporary, plan-initiated disenrollment may be obtained through DHCS.

Eligibility Reports

The plan generates eligibility reports twice a month to provide information about member assignments to participating physician groups (PPGs). The health plan also generates eligibility reports to help PCPs keep track of their new members and members who need DHCS-required exams. Consult the 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. 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, the health plan will not accept financial responsibility for any services performed.

Eligibility Verification Systems

Eligibility can be verified using one of the following options:

- The provider website.
- Medi-Cal Provider Services Center at 1-888-893-1569.
- Point of Service (POS) device.
- CERTS software.
- TransUnion® MedConnect website at www.meddatahealth.com/login.aspx or by telephone at 1-800-633-3282.
- Provider's clearinghouse.

Consult the Medi-Cal provider operations manuals for details.

Provider Enrollment Requirements through DHCS

Providers who wish to participate in the plan'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

The plan 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 the plan must verify that their network of providers involved in servicing CalViva Health 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.

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Chapter 3 – Access to Care

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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 care 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

<i>Type of Care</i>	<i>Approximate Wait Time</i>
Emergency care	Immediately
Urgent care visit with a PCP or specialist that does not require prior authorization	Within 48 hours of request
Urgent care visit requires prior authorization	Within 96 hours of request
Non-urgent/routine care with a PCP	Within 10 business days of request for an appointment
First prenatal visit with a PCP or specialist	Within 10 business days of request for an appointment
Specialty care referral	Within 15 business days of request for an appointment (based on severity of condition)
Physical exams and wellness checks	Within 30 calendar days of request for an appointment
Well-child visit with a PCP	Within 10 business days of request for an appointment
Initial health assessment for members	Within 120 calendar days of enrollment
Non-urgent ancillary services for MRI/mammogram/physical therapy	Within 15 business days of request
Non-urgent appointment 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

Behavioral Health Appointment Access Standards (Applies to MHN providers only)

<i>Type of Care</i>	<i>Standard</i>
Non-urgent/routine care with a mental health physician	Within 15 business days of request
Non-urgent care with a mental health provider (non-physician)	Within 10 business days of request
Access to urgent mental health care	Within 48 hours of request
Access to non-life-threatening emergency mental health care	Within 6 hours of request
Access to mental health care for life-threatening emergency care	Immediately

The following access standards also apply:

- In-office wait time for scheduled appointments must not exceed 30 minutes.
- Medical services must be available 24 hours a day, seven days a week.
- Telephone service must be available 24 hours a day, seven days a week.
- During office hours, office staff must answer 80 percent of telephone calls within 60 seconds and return member phone calls within one business day.
- After office hours, physicians must return telephone calls and pages within 30 minutes.

Facility Access for the Disabled

Participating providers 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 site review process includes the Physical Accessibility Review Survey (PARS) (refer to Chapter 8 for facility site review information). 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 included in the CalViva Health website, the provider directory and made available to the Medi-Cal Member Services Department. The provider directory assists members in selecting a PCP that can best serve their health care needs.

Seniors and Persons with Disabilities Training Available

On behalf of CalViva Health, Health Net, in conjunction with the Harris Family Center for Disability and Health Policy (CDHP), offers an online Seniors and Persons with Disabilities (SPD) training program for participating providers and their staff on the Harris Family CDHP website. The training is designed to increase awareness, competency and the ability to provide accessible health care services to the Medi-Cal SPD population.

To access the online training modules, providers must register on the Harris Family CDHP website as follows:

1. Go to <https://www.hfcdhp-training.org>.
2. Select *Site License Inquiry for Groups & Institutions* under *How to sign up*.
3. Complete the *Site License Inquiry Form* on the registration page.
4. Participating providers have access to training modules one, three and four.
5. Select *Submit this form*.

Providers will receive an email from the Harris Family CDHP with instructions on how to verify enrollment and begin training.

In addition to the video modules, providers and their staff can also access succinct, self-guided PowerPoint presentations regarding providing accessible health care services to SPD members as follows:

1. Go to <http://www.hfcdhp.org>.
2. Select *Training*.
3. Select *Primary and Specialty Care Practitioners – Front Office Staff* or *Primary and Specialty Care Practitioners – Medical Office Staff* to view available training material.

After-Hours Access

The health plan requires physicians, or a registered nurse under physician supervision, to maintain 24-hour telephone coverage seven days a week through their answering service or 24-hour on-site medical care for members.

PCPs who do not have services available 24 hours a day may use an answering service 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. Sample scripts are available in the Provider Library. Physicians must return after-hour telephone calls and pages within 30 minutes.

Emergency Telephone Numbers

Emergency and poison control telephone numbers must be posted near the office or facility telephones.

Access to Confidential and Sensitive Services

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

Freedom of Choice

Medi-Cal members have the freedom of choice to receive timely and confidential family planning services, diagnoses 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. Members ages 12 and older may obtain sensitive services without parental consent.

Sensitive Services

Sensitive services include services related to sexual assault, drug or alcohol abuse treatment, pregnancy, family planning, HIV counseling and testing, mental health treatment, and diagnosis and treatment of STIs.

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 non-participating providers as outlined in Chapter 5.

Obstetrical care for pregnancy must be accessed through a participating 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 the health plan's coverage responsibilities. These services are covered, administered and paid for by sources other than the health plan. The health plan is not 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 plan employees and participating providers must maintain the confidentiality of information pertaining to the member's access to these services.

Nurse Advice Line

Access-to-care standards require all PCPs to provide 24-hour telephone service for instructions, medical condition assessment and advice. While assistance via telephone is the PCP's responsibility, the Medi-Cal Member Services Department can assist members in reaching their PCP when needed. The Medi-Cal Member Services Department 24-hour toll-free number is printed on the back of the member's identification (ID) card. The Medi-Cal member services representative can either get the member in contact with the PCP, or, if the PCP is not available or at the member's request, the call can be routed to the nurse advice line.

The nurse advice line is staffed by registered nurses who can assess a member's medical condition and, through conversation with the caller, take further action, including referral to a health care provider or facility, and offering instructions on home care techniques and general health information.

Emergency and Urgent Care

Emergency services are covered under the CalViva 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),

- 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 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). Follow-up service for an urgent care medical condition requires prior authorization if treatment is rendered by a provider other than the PCP or the on-call designee.

Telephone Assessment

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

Community-Based Adult Services

Community-based adult services (CBAS) provide a variety of health, therapeutic and social services to eligible Medi-Cal members ages 18 and older.

CBAS offers a bundle of services during a service day based on medical criteria and member's need. The number of days per week that members receive services is included in their CalViva Health-approved individual plans of care (IPCs). 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 CalViva Health member may benefit from the CBAS program must contact the CBAS Request Line for a face-to-face assessment and arrange transportation to and from the center for assessment.

The plan completes an initial face-to-face assessment using the CBAS Eligibility Tool to determine eligibility for CBAS. Once eligibility is validated, the plan notifies the CBAS center to complete the evaluation of services needed and develops an IPC. The CBAS center submits the evaluation and IPC, signed by all appropriate team members, to CalViva Health for authorization of services and number of days per week the member is eligible for services.

The CBAS center is responsible for requesting and obtaining authorization for services. CBAS is a Medi-Cal managed care benefit, and CalViva Health is financially responsible for covered services provided by CBAS centers.

Long-Term Services and Supports (LTSS)

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

CalViva Health members obtain the following mental health services through MHN, Health Net's behavioral health subsidiary:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing to evaluate a mental health condition.
- Outpatient services that include laboratory work, medications and supplies.
- Outpatient services for the purposes of monitoring medication therapy.
- Psychiatric consultation.

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 MHN's extensive behavioral health network by calling the member services telephone number listed on the back of their ID cards. Providers may also refer members to CalViva Health 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 MHN, Health Net's behavioral health subsidiary. Providers may submit treatment referrals to MHN by calling the member services telephone 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)-eligible members identified as needing BHT services, regardless of diagnosis, to MHN for assessment and referral to a mental health provider. The plan coordinates with MHN to manage 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.

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.

Non-Emergency Medical Transportation

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. This includes door-to-door assistance for all members receiving NEMT services.

NEMT modalities include:

- 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:
 - Requires a member be transported in a prone or supine position because the member is incapable of sitting for the period of time needed for transport.
 - Requires specialized safety equipment 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:
 - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
 - Requires that the member 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.
 - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

Non-Medical Transportation

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.

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. The health plan 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 either:

- At least 3,000 people or five percent of the Medi-Cal population with mandatory aid codes, whichever is lower, in a county have declared their primary language to be other than English.
- At least 1,000 Medi-Cal eligibles residing in a single ZIP code or 1,500 in two contiguous ZIP codes have made this declaration (this is known as a "language concentration").

The current threshold languages by county are:

- Fresno – Hmong and Spanish
- Kings – Spanish
- Madera – Spanish

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 limited-English proficient (LEP) members 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 LEP members that are as effective as those provided to non-LEP members.
- 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 charge.
- File a complaint or grievance if language needs are not met.
- Not use family members or friends 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.

Services That Do Not Require Referral or Prior Authorization

Referral or prior authorization is not required for the following services. Members may obtain these services from any qualified in-network or out-of-network provider:

- Emergency services
- Family planning services (includes visits to an OB/GYN for an annual Pap test and pelvic examination)
- HIV testing
- Referral or prior authorization is not required for the following sensitive services, and the services may be obtained from any qualified in-network or out-of-network provider:
 - Minor consent services – those covered services of a sensitive nature that minors do not need parental consent to access or obtain. Such services are those related to sexual assault, including rape; drug or alcohol abuse (for children age 12 and older); family planning services; prevention or treatment of pregnancy; HIV counseling and testing; sexually transmitted infection (STI) diagnosis and treatment (for children ages 12 or older); and outpatient mental health services
 - Therapeutic and elective pregnancy termination
 - Family planning, STI diagnosis and treatment, HIV testing and counseling, and sexual assault services
- Comprehensive Perinatal Services Program (CPSP) services. Services may be obtained from any participating CPSP provider; prior authorization is not required.
- Other services not requiring prior authorization:
 - 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 needs services when the member is outside of their county
- Certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider do not require prior authorization.

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.
- For services with an out-of-network specialist, the PCP completes and mails or faxes the Request for Prior Authorization form to the specialist with the authorization number attached.
- For specialty visits with participating specialists, there is no need to complete a Request for Prior Authorization form or notify the health plan. 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, the health plan 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 non-participating providers require prior authorization from the Health Care Services 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

The health plan delegates the referral process to full and shared-risk PPGs. Referrals to participating and non-participating 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 non-participating providers require prior authorization from the PPG or the health plan.

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 telephone report to the PCP as soon as possible, and a written report should be received within two weeks.

Referrals to Public Programs

Many 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 Medi-Cal provider operations manuals, located in the Provider Library.

Provider Responsibilities for Referral Tracking

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 PCP.

PCPs are responsible for maintaining continuity of care for members during the referral process. This may entail monitoring referrals made for their 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.

The health plan also has responsibilities for tracking referrals. Additional information about these responsibilities and the tracking systems in place is available in the Medi-Cal provider operations manuals located online in the Provider Library.

Prior Authorization Requests

Prior authorization is designed to ensure 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 Health Care Services Department.

Providers contracting directly with the health plan (FFS providers) must obtain prior authorization from the Health Care Services Department. The health plan has delegated the prior authorization process to some PPGs. Prior authorizations for members assigned to a delegated PPG are subject to any additional rules imposed by the PPG or subcontractor. PPGs or subcontracting 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

The prior authorization process for FFS providers enables providers to coordinate medically necessary care in the most timely and efficient manner.

- Prior authorization is not required for most common services, including referrals to 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 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. The health plan 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.
- The PCP and specialist retain a copy of the Request for Prior Authorization form in the member's chart.
- The PCP faxes a copy of the Request for Prior Authorization form to the local health services department.
 - This ensures that the health plan identifies case management needs and assists the member with coordination of care, when appropriate.
 - This also enables the health plan to assist in the detection of and referral to appropriate agencies for carve-out services, such as CCS, regional center and specialty mental health.
- Specialists submitting paper claims 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 Health Care Services Department as much advance notice as possible when requesting prior authorization. For 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. It is strongly recommended that services not be scheduled prior to receiving the Health Care Services 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 Health Care Services Department, as listed in Chapter 1 of this guide. Requests are processed Monday through Friday, 8:00 a.m. to 5:00 p.m. Providers may request blank forms by calling the Medi-Cal Provider Services Center.

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 telephone by calling the Health Care Services 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, telephone 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.
- Whether services are outpatient or inpatient.

The Health Care Services 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 CalViva Health 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 CalViva Health *Recommended Drug List (RDL)* require prior authorization for coverage. Physicians and pharmacies receive a notification of decision within 24 hours or one business day if all the required information is provided on the Prescription Drug Prior Authorization Request Form. Requests may be electronically submitted, faxed to the pharmacy benefit manager or submitted by any reasonable means of transmission.

Medications not on the list may be requested using the prior authorization process if alternatives on the CalViva Health *RDL* have been tried without success or are contraindicated. The CalViva Health *RDL* is available electronically on the CalViva Health website at www.calvivahealth.org/providers.

Chapter 4 – Medical Standards

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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; Child Health and Disability Prevention (CHDP) Program guidelines; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services guidelines; American Academy of Pediatrics (AAP) guidelines; initial health assessments (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 5.3, 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 PCP is responsible for the following:

- Providing an initial health assessment (IHA), which includes an age-appropriate history, physical examination and individual health education behavioral assessment (IHEBA), within 120 calendar days after the member's date of enrollment.
- Completing an IHEBA using the Staying Healthy Assessment (SHA) as indicated by the periodicity table. Adults and seniors assessment is completed every three to five years.
- Notifying members of periodic or clinically indicated appointments.
- Documenting assessment findings, treatment, 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

<i>Age</i>	<i>Frequency</i>
0-20	Refer to AAP Recommendations for Preventive Pediatric Health Care in the Medi-Cal provider operations manuals
19-25	Annually
26-39	Annually
40-49	Annually
50-65	Annually
65 and older	Annually

Initial Health Assessment

All new Medi-Cal members must receive an IHA, which includes an age-appropriate history, physical examination and individual health education behavioral assessment (IHEBA) within 120 calendar days of 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.

Providers must complete the IHEBA as part of the IHA. CalViva Health and Health Net recommend providers use the Department of Health Care Services (DHCS)-approved IHEBA, the SHA. Refer to PCP Responsibilities on page 4.1 for more information.

Guidelines

For members ages 21 and older, the IHA must follow the DHCS guidelines and the health plan's preventive care services guidelines. The preventive care guidelines in the Guide to Clinical Preventive Services (U.S. Preventive Services Task Force) are considered the minimum acceptable standards for adult preventive care services. A member's risk factors affect the type and quantity of preventive services needed. A member may need additional services at more frequent intervals.

For members under age 21, the IHA and ongoing assessments must follow the requirements of the CHDP program.

For both adults and children, the IHA must include health education behavior assessments to determine health practices, values, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, and health education needs.

For all providers, a member eligibility report is available through Membership Accounting at the 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 online IHA reports located under Provider Reports on the Health Net website.

The plan reviews monthly claims and encounter data of initial health assessments 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

New members are sent a welcome packet that includes an IHA notification and information about how to schedule an appointment with their PCP. 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 assessments, PCPs must inform members, parents or guardians about the need for and importance of periodic health assessments and reinforce the member's understanding of the need for routine health care services or Child Health and Disability Prevention (CHDP) program services at each medical encounter. PCPs are encouraged to schedule the next visit at the conclusion of the 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 the Health Plan

The health plan sends new members a welcome packet that includes an initial health assessment (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. The health plan contacts new Medi-Cal members by telephone after mailing the new member packet to discuss 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, the plan conducts a third member contact via postcard. 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 records.

Refugee Health Assessment

Members in the Refugee Assistance Program should have received a refugee health assessment through the Refugee Assistance Program prior to enrolling with the health plan. To inform the medical home and ensure medical records are as complete as possible, providers are reminded to request these documents from the Refugee Health Program in the member's county of residence.

Public programs administrators assist in the transfer of medical information to the PCP for newly enrolled members previously enrolled in the Refugee Assistance Program.

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.

Child Health and Disability Prevention Program

The CHDP program is a preventive screening program for low-income children under age 21. It encompasses the requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the Prenatal Guidance program. The purpose of the CHDP program is 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 CHDP program within one year of contracting with the plan. CHDP enrollment is offered at no charge to providers by the county CHDP program and usually involves an interview and office evaluation. Non-CHDP-enrolled providers may obtain enrollment information by contacting the local CHDP office or, if further assistance is needed, the plan's public programs administrators.

CHDP Appointments and Referrals

Medi-Cal members requesting an appointment with their PCP or mid-level provider must be scheduled for an appointment within 10 days if the child is behind schedule for a CHDP program exam. If the PCP cannot provide the needed services within 10 days, the PCP may refer the member to another participating provider, out-of-network CHDP provider, local health department (LHD), or school-based CHDP 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 Medi-Cal Member Services Department, a representative makes contact with the member's PCP to determine whether the member is in need of current CHDP services and to assist with appointment scheduling, if needed.

Disenrolled Population

The Disenrollment Report is prepared monthly for the public programs administrators. The public programs administrators coordinate with the CHDP program to share this report. Appropriate preventive care visits for this disenrolled population are subsequently arranged by the county CHDP program.

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 within the member's ZIP code. The PCP is also responsible for dental assessments. Refer to the discussion of Dental Screenings on page 4.11 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 after the health assessment appointment at which the condition was identified. The Health Care Services 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 upon request without having to work through the physician extender.

Public programs administrators receive information from the Medi-Cal Member Services Department regarding members who have disenrolled. The public programs administrators inform the local CHDP program office of the mandatory disenrollment of members under age 21 and assist in transition of care as necessary.

If members in need of transportation assistance do not meet the criteria for non-emergency transportation, the PCP refers the member to the CHDP program office.

Obtaining Consent

Providers must obtain the voluntary written consent of the member, parent or guardian before performing a CHDP exam. Consent is also required for any release of medical information. The CHDP program has a standard consent form (PM 211) 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, and the county CHDP program should be informed. The provider may contact the county CHDP office directly, or may request assistance from the health plan's public programs administrator or the provider's affiliated plan.

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 CHDP 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 CHDP 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. It is the policy of the CHDP program and local schools to 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 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 telephone call 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 any follow-up attempts in the member's medical record. After two no-shows, the PCP is required to contact the health plan's public programs administrator, who will contact the CHDP program for case management and referral assistance.

CMS-1500 Form Coding Instructions

For FFS physicians, CHDP program services are billed on a CMS-1500 form using appropriate CPT/HCPCS codes. The CHDP indicator "3" must also be entered in the box 24H (EPSDT/family planning) of the CMS-1500 form to indicate that the visit was for CHDP services.

For capitated physicians, the CHDP program services must be reported as a Medi-Cal encounter to the health plan for reporting to DHCS.

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

Physician Office CHDP Services

<i>Procedure Description</i>	<i>CMS-1500 CPT/HCPCS Procedure Code</i>
Physical exam, new patient, birth–11 mos.	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 mos.	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*

<i>Procedure Description</i>	<i>CMS-1500 CPT/HCPCS Procedure Code</i>
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
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, or 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 CHDP Services*

<i>Procedure Description</i>	<i>CMS-1500 CPT/HCPCS Procedure Code</i>
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 CHDP Services with School-Based Programs

The health plan’s policy on routine CHDP program services is that services should be 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.

The health plan has entered into contracts and agreements to provide and coordinate health care services where school-based clinics operate under the auspices of a PPG. Members who are identified at school sites as being in need of CHDP services may receive these services from the contracting school-based clinics within the required state and federal time frames. The health plan follows up and documents that CHDP services are provided to members. 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 being in need of CHDP 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 plan provider, out-of-network provider, LHD, or PPG-linked school-based clinic.

EPSDT Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members under age 21 are based on 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 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 services include case management and targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services.

Health Care Services staff or delegated PPGs coordinate with PCPs to identify children under age 21 who would benefit from these services and assists with appointment scheduling. The health plan determines medical necessity of EPSDT services according to the criteria established by DHCS. When the EPSDT services are provided for the California Children's Services (CCS) program or are specialty mental health services (which are carved out from coverage responsibilities), the health plan does not determine medical necessity.

Health Care Services staff or delegated PPGs ensure that members under age 21 who qualify for EPSDT services are referred to an EPSDT services provider or to an entity that provides EPSDT services, such as a regional center. If these referred providers render EPSDT care management services, the care manager and health plan medical director or delegated PPG medical director determine medical necessity. If EPSDT care management services are not available from these referral providers, the health plan or delegated PPG arranges and pays for EPSDT 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 program eligibility is pending. The EPSDT benefit is more robust than the Medi-Cal benefit package required for adults, and states may not impose limits on EPSDT 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 (case management services and other services), if services are not available from EPSDT 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 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, the local CHDP program, or by an encounter with another health care provider. Providers must direct all referrals for EPSDT services to the Health Care Services Department, delegated PPG or, where applicable, subcontracting provider organization. Health Care Services staff and the health plan's Medi-Cal medical directors or delegated PPG medical directors review requests and determine medical necessity for EPSDT services.

Care Coordination

Health Care Services staff or the delegated PPG works in coordination with the public programs administrators to monitor the appropriate use of local government organizations, including regional centers, which provide EPSDT services. The Health Care Services 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 plan medical director or delegated PPG medical director, Health Care Services staff or the PPG coordinates the services with the PCP. If EPSDT services are not available through a local government agency or organization, Health Care Services staff or the delegated PPG issues letters of authorization and negotiated claims payment instructions to EPSDT 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. The plan must ensure that appropriate EPSDT 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 case management services:

- Member and family education regarding EPSDT services.
- Referral to EPSDT case management services.
- Reason for referral.
- Member or family response to referral.
- Subsequent case management plan.

Problem Resolution

Health Net's public program administrators, on behalf of CalViva Health, resolve disputes that arise regarding responsibility for necessary EPSDT services. Health Care Services 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.

Immunizations

PCPs are responsible for administering immunizations to members. Local health departments (LHDs) may also immunize Medi-Cal members.

Administration of Immunizations

Primary Care Physicians

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 CalViva Health 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 non-participating 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, the health plan 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, the health plan 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. Refer to the Medi-Cal provider operations manuals for enrollment information.

Member Outreach and Education

The health plan'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 newsletters and brochures, which are available through the Health Education Department toll-free information line.

Reimbursement

For immunizations of members ages 19 and older, FFS participating providers are reimbursed at the Medi-Cal FFS program rate, which includes an allowance for the vaccine and its administration.

Public Programs Coordination

Public programs administrators work 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 manuals in the Medi-Cal Provider Library for periodic health exam schedules).

Dental services other than dental screenings are not covered under the health plan's Medi-Cal contracts. The health plan is not financially responsible for covering dental services under any circumstances, including when they are provided as an EPSDT service. Participating PCPs refer members for dental services to Medi-Cal dental providers.

The health plan 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 and anesthesia services for inpatient and outpatient services (such as ambulatory surgery center) that are prior authorized.
- Physician-administered anesthesia services (such as intravenous (IV) sedation and 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 six.

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 CHDP program 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 an initial dental exam referral to a Medi-Cal-approved dentist when the member reaches age three, or earlier if dental problems are identified, and continue to refer the member annually. 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 and on the DHCS PM 160 INF form.

Providers or members may call Denti-Cal at 1-800-322-6384 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 Provider Directory for a list of participating optometrists and ophthalmologists. Providers should contact the Medi-Cal Provider Services Center 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 three. 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 the Medi-Cal plan:

- Routine eye examination 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.
- Contact lenses, when medically necessary, for eligible members under age 21 or members residing in skilled nursing facilities (SNFs). Adults ages 21 and over 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 the following:
 - members under age 21
 - members residing in skilled nursing facilities or immediate care facilities
 - pregnant women through postpartums

Polycarbonate Lenses

Polycarbonate lenses are covered for the following:

- Member is age 18 or younger.
- Member over age 18 meets one 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 10 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 Envolve Vision for those identified above.

Eyewear for members over age 21 is not a benefit of the Medi-Cal program.

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 to either eye of 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 and 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.
- Eyewear for members age 21 and older, unless residing in a skilled nursing facility or intermediate care facility or for pregnancy-related services for the treatment of other conditions that might complicate the pregnancy.

Pregnancy and Maternity Care

Members may see any qualified participating provider, including their PCP, OB/GYN, or certified nurse midwife (CNM) and certified nurse practitioner (CNP), for prenatal care. PCPs and specialists are prohibited from requiring a referral or prior authorization for basic prenatal care. If there are no CNMs or CNPs in the PPG network, access to non-contracting CNMs or CNPs is covered.

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. The health plan has developed assessment tools approved by DHCS that are included in the Forms 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 all California Department of Public Health (CDPH)-certified CPSP providers who contract with the health plan or a subcontracting health plan.

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 Congress of Obstetricians and Gynecologists (ACOG) recommendations and within accepted health plan 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.

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

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 well-child care CHDP 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 is outlined below. PPG providers 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 a 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 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 Medi-Cal Health Care Services Department.

Monitoring and Oversight

The health plan assesses and tracks participating providers' ability to deliver CPSP services required by Medi-Cal law according to the ACOG *Guidelines for Perinatal Care* and health plan policies. The plan monitors compliance and provision of obstetrical services according to the ACOG *Guidelines for Perinatal Care*.

Billing

Individual participating providers 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.

Special Supplemental Nutrition Program for Women, Infants, and Children

WIC is a 100 percent 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 percent of the federal poverty level) women and children up to age five. 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 covered benefits under the Medi-Cal managed care program. When prescribing a medically necessary/therapeutic formula, providers must request authorization from their plan.

Identifying Eligible Beneficiaries

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

- Pregnant women.
- Breastfeeding women (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 five.
- Those who are 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, the health plan 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).
- CHDP Program form.
- 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.

The Public Programs Department negotiates a memorandum of understanding with local WIC agencies to facilitate coordination and communication between the health plan and the agency. Public programs administrators also work with WIC agency liaisons to handle conflicts that might arise between the WIC agency and the health plan or a participating provider.

Chapter 5 – Sensitive and Self-Referral Services

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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 3.1. A summary, the Medi-Cal Referral Variations Matrix, is included on page 5.3.

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 the health plan 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-network provider, and some of these services may be provided by qualified out-of-network providers. The health plan 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 below, and are categorized by age as follows:

	<i>Minor may consent if age 12 and over</i>	<i>Minor may consent if under age 12</i>
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

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

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.
- Mental health care – Refer to the Public Programs topic for additional information. Members ages 12 or older who are mature enough to participate intelligently, and where either there is a danger of serious physical or mental harm to the minor or others, or the member is the alleged victim of incest or child abuse, are entitled to timely, confidential referral to the local mental health program.

Medi-Cal Referral Service Variations

	<i>Mandatory Referral¹</i>	<i>Self Referral²</i>	<i>Out-of-Network Provider³</i>
CHDP 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 dept. only
OB care		X	No
STIs		X	Yes
WIC	X		N/A

¹Program-mandated services to which a PCP must refer the member.

²Services that may be accessed by the member at any time without a referral or authorization.

³Services members may obtain from a non-participating provider as indicated.

⁴Obstetric care providers caring for a newborn must inform the mother of required CHDP services and refer the member to a CHDP provider.

Family Planning Services

Medi-Cal members have the right to access family planning services without referral or prior authorization from any qualified participating or non-participating family planning provider in- or out-of-network. A qualified participating or non-participating provider includes a member's PCP, other participating or non-participating provider, OB/GYN, nurse midwives, nurse practitioners (NPs), physician assistants (PAs), federally qualified health centers (FQHCs), 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.

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 non-participating 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 (one visit per episode when provided by non-participating providers).
- 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 12 vaginal rings, 36 patches and 13 cycles of oral contraceptives.
- 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 non-participating 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

The health plan provides members the following information on family planning services in the *Evidence of Coverage (EOC)*:

- 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 non-participating 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

The plan encourages the PCP to coordinate care with non-participating providers to avoid duplication of services. If the PCP previously provided the service the non-participating provider is now providing, the non-participating 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 non-participating 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 non-participating provider.

If the member needs medically necessary follow-up care, the non-participating provider must obtain signed consent from the member to notify their PCP. Health Care Services staff are available to assist non-participating 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 the health plan's public programs administrators for resolution. During any problem periods, a health plan care manager and the PCP or specialty provider continues to coordinate the member's care.

HIV Testing and Counseling

Providers offer confidential HIV testing, counseling and follow-up services to Medi-Cal members. Providers must provide information about HIV testing, treatment options and additional testing needed, and advise members of their right to decline testing. If a member declines HIV testing, providers must document this information in their medical records.

Members may also obtain confidential or anonymous HIV testing and counseling services from the local health department (LHD), community-based organization testing site or non-participating family planning provider. The member's PCP must perform follow-up services.

Mandatory Offering

PCPs are required to counsel and offer HIV testing to pregnant Medi-Cal members. The health plan 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.

Testing, Counseling and Follow-Up

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-test counseling.

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

Pregnancy services are covered in chapter 4 of this guide beginning on page 4.14.

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-network, 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 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 a federally qualified health center (FQHC).

Sexually Transmitted Infections

Diagnosis and treatment of STIs are available to 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 visit for STIs that are amenable to immediate diagnosis and treatment, including bacterial vaginitis, trichomoniasis, candidiasis, herpes simplex, human papillomavirus (HPV), gonorrhea, non-gonococcal urethritis, and Chlamydia.
- One initial visit for primary or secondary syphilis and up to five additional visits for clinical and serological follow-up and treatment.
- A maximum of three visits for diagnosis and treatment of chancroid, lymphogranuloma venereum, granuloma inguinale, and pelvic inflammatory disease (PID).

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 the discovery 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 telephone number, date of birth, gender, ethnicity, and marital status).
- Locating information (employer, work address and telephone number).
- Disease information (diagnosed date of onset, symptoms, laboratory results, and prescribed medications).

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.

Non-Participating Providers

The health plan requests that non-participating providers contact the Medi-Cal Member Services Department to verify eligibility and benefits and to obtain billing instructions for Medi-Cal members. The non-participating provider is given the name of the member's PCP to arrange for follow-up services. Non-participating providers may also use either a Point of Service (POS) device or the Affiliate Computer Services (ACS) by telephone to confirm eligibility. If the non-participating provider contacts the PCP directly, the PCP is responsible for coordinating the member's care with the non-participating provider.

If the non-participating provider requests care management services, the request is forwarded to the Health Care Services Department. The Health Care Services Department arranges for any necessary follow-up care and coordinates with the member's PCP.

Member Education

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 Facility Site Review (FSR) Compliance and Health Education departments send STI health education information to providers on request.

Reimbursement

Participating Providers

Participating providers must bill in accordance with their *Provider Participation Agreements (PPAs)*.

Individual 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*.

Claims for reimbursement are processed within 30 days of receipt, unless the *PPA* requires that claims be processed sooner. Providers are notified in writing of any contested claim in suspense longer than 30 days.

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.

Chapter 6 – Public Health Carve-Out Services

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Public Health Carve-Out Services

Public health programs provide a wide variety of services to Medi-Cal members at the county, state and federal levels. Physicians, public health programs and the health plan 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 the health plan. Members using these services continue to be enrolled with the health plan.

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 6.2, 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 Health Care Services 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 the health plan or the primary care physician (PCP) are handled by the health plan’s public programs administrators. During any such period, a 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
AIDS waiver	X	X		X (patient choice)		PCP, Specialist	Local AIDS Waiver Prog.	Local AIDS Waiver Prog.
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 ³		PCP	IHO Sacramento	IHO Sacramento
Home & Comm. Based waiver – DOA (MSSP)	X	X			X	PCP	Dept. of Aging Local Contractor	Dept. of Aging Local Contractor
LEA	X		X		X	Self, PCP	LEA	LEA
Long-term care	X		X	X		PCP, Specialist	TAR, Local MC	MCFFS
Specialty mental health only	X		X		X	PCP, Self	County Mental Health Plan	County Mental Health Plan
Organ transplant – adult	X		X	X		PCP, Specialist	SF Reg. MC Office	MCFFS
Kidney	Covered		X		X	PCP, Specialist	PLAN	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

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

²Programs in which the payer is other than Health Net and the member is not disenrolled (exceptions: organ transplant and LTC).

Alcohol and Drug Treatment Services

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

The health plan and its subcontracting providers are available to coordinate referrals for members requiring substance abuse treatment and services. Members receiving services under this program remain enrolled in the plan. Participating PCPs are responsible for maintaining continuity of care for the member.

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.

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 provider 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 the health plan's confidentiality standards.

A member receiving services under the Alcohol and Drug Treatment Program remains enrolled with the health plan. The PCP and Health Care Services 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 Health Care Services 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 the health plan 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. These services include comprehensive history and physical examination, including neurological and developmental assessment, ophthalmological and audiological evaluations, and family psychosocial and home assessment, including coordination of HRIF services during the first three years of life.

HIV Children's Screening Program

The Department of Health Care Services (DHCS) Office of AIDS provides funding for the CCS HIV Children's Screening Program. CCS issues authorization to a CCS-approved Infectious Disease Immunology Disease Special Care Center (IDID SCC) for outpatient diagnostic services for infants and children under age 21 who are at risk for HIV infection. Authorizations for diagnostic services are not to exceed six months.

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 who 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 percent of the family's adjusted gross income.

CCS-Eligible Conditions

The following is a categorical list excerpted from the CCS Medical Eligibility Regulations identifying the general types of conditions 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.
- Neoplasms.
- Endocrine, nutritional and metabolic diseases and immune disorders.
- Diseases of blood and blood-forming organs.
- Mental disorders and mental retardation.
- Diseases of the nervous system.
- Diseases of the eye.
- Diseases of the ear and mastoid process.
- Diseases of the circulatory system.
- Diseases of the respiratory system.
- Diseases of the digestive system.
- Diseases of the genitourinary system.
- Diseases of the skin and subcutaneous tissues.

- Diseases of the musculoskeletal system and connective tissue.
- Congenital anomalies.
- Accidents, poisonings, violence, and immunization reactions.
- 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, teacher, or parents). A referral may be sent on a CCS/GHPP SAR form or in a letter including all of the following information:

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

PCPs and specialists' 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 or letter 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 telephone number of the referral source.
- Completed CCS Application for Service form (if available at the physician's office at the time of referral).

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 the health plan 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. A printable copy of the form is available online in the Provider Library.

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) 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 Delegation Oversight Department. The health plan is available to work with participating providers and care managers to facilitate referrals to CCS and continuity of care as needed.

County Mental Health Plan

Services available under the Medi-Cal specialty mental health program are excluded from the health plan's coverage responsibilities. 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 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 the plan. 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 MHN 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 manifestations.
- 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 MHN.
- For members with a severe level of impairment, refer to CMHP for specialty mental health services (SMHS).

Members may also self-refer to MHN by calling the member services telephone number listed on their identification (ID) card. The member services representative transfers the member's call to MHN on behalf of the member.

Health Plan Responsibilities

The health plan is responsible to:

- Cover all psychotherapeutic medications prescribed by participating PCPs and non-participating 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) 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 are 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 the health plan 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 health plan's public programs administrators and the Health Care Services 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 medications 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 medication 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 telephone call or letter should be initiated. If there is no response, the PCP notifies the LHD TB Control program.

Tracking and Coordination of Care

The health plan'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 or the public programs administrators, the Medi-Cal Health Care Services Department is available to provide assistance with coordinating the member's care.

Early Start Program

The Early Start program provides 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 are determined to have a significant difference between the expected level of development for their age and their current level of functioning. The health plan identifies children under age three 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 physical evaluation.
- Developmental screening.
- Diagnosis and, if possible, etiology.

PCPs are responsible for referring infants and toddlers identified as needing early intervention services for evaluation to the local DDS Early Start program 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 the 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
 - visual or hearing impairments
 - family history of developmental delay

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. The health plan may provide either written or telephone 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 program services are indicated.

Coordination of Care

The health plan assists PCPs and families with referrals of identified children under age three 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 telephone 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 Health Care Services Department when necessary.

Public Programs Coordination

Public programs administrators are available to participate in the community Local Interagency Coordination Areas (LICA). Public programs administrators work 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.

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.

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. If the member requires care in one of the following facilities for longer than the month of admission plus one month, the health plan coordinates the member's disenrollment and transfer of coverage to the Medi-Cal FFS program:

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

The health plan arranges the transfer of the member to a participating Medi-Cal-approved facility that provides one of the services listed above. If the plan does not participate with a Medi-Cal-approved facility, it arranges for the member's transfer to a FFS Medi-Cal-approved facility.

Hospice services are not considered LTC services. When hospice services are provided in an LTC facility, the member is not disenrolled from the health plan.

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 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 – The health plan's or 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.

Disenrollment

Medi-Cal members in need of LTC facility services are placed in health care facilities providing suitable levels of care most appropriate to their medical needs. The health plan does not cover LTC services. When members require LTC longer than the month of admission plus one month, the plan coordinates the member's transfer of coverage to the Medi-Cal FFS system. Hospice services are not considered LTC services. When hospice services are provided in a LTC facility, the member is not disenrolled from the health plan.

The Medi-Cal Member Services Department is responsible for logging all disenrollment requests. The requests are then sent to the DHCS and HCO for review and approval. Responses are tracked by the Medi-Cal Member Services Department.

Once approval is received from DHCS, the member is disenrolled from the health plan and receives services through the Medi-Cal FFS system. An approved disenrollment request is effective the date DHCS indicates the beneficiary is no longer enrolled in the managed care health plan.

The Medi-Cal Member Services Department notifies the care manager of the member's disenrollment. The care manager then notifies the facility and coordinates orderly transfer of the member's care to Medi-Cal FFS without interruption of services. The nursing facility or discharge planner at an acute hospital is responsible for completing the Long Term Treatment Authorization Request (LTC TAR, form 20-1) and submitting it to the Medi-Cal field office for approval of the member's admission to the nursing facility. All services are covered and coordinated by the health plan until disenrollment is complete.

If the request for disenrollment is denied, the Medi-Cal Member Services Department notifies the care manager of the member's continued enrollment. The member continues to receive coordinated care management services through the health plan or the subcontractor responsible for providing such services.

The care manager notifies one of the health plan's Medi-Cal medical directors of the denial, and the medical director reviews the denied request. A medical director who decides that a denial was incorrect contacts a public programs administrator, who then initiates the problem resolution process with DHCS.

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 Public Programs Department.

Major Organ Transplants for Adults

The following major organ transplants are not covered under the health plan's Medi-Cal Managed Care contracts:

- Bone marrow and stem cell transplants.
- Heart transplants.
- Liver transplants.
- Combined liver and small bowel transplants.
- Lung transplants.
- Combined heart and lung transplants.
- Combined liver and kidney transplants.
- Small bowel transplants.

Exception

Members ages 21 and older requiring kidney transplants remain enrolled with the health plan during treatment and transplant.

All major organ transplants, including kidney transplants, for members under age 21 are coordinated through the CCS program.

Selection Criteria

The health plan follows the Medi-Cal Patient Selection Criteria for Covered Transplants, developed by the Medi-Cal Advisory Committee on Anatomical Transplant (MACAT), when reviewing all pre-transplant evaluations.

Referral Process

A PCP or specialist who identifies a member as a potential candidate for transplant services must submit a request for transplant evaluation to the Health Care Services Department. The member may also initiate the request for transplant evaluation.

On receipt of a request for transplant evaluation, a care manager contacts the provider and requests the member's medical records, and completes the member clinical profile.

When the complete medical records are received, the care manager and Medi-Cal medical director review the information to establish medical necessity. If approved, the care manager forwards the information to the Medi-Cal-approved transplant center for pre-transplant evaluation.

Coordination of Care

Once the member has been determined to be a transplant candidate, the physician scheduled to perform the transplant submits a Treatment Authorization Request (TAR) form to the San Francisco Medi-Cal field office or submits a Service Authorization Request (SAR) to the local CCS program office for members under age 21. A care manager stays in contact with the Medi-Cal-certified transplant facility care manager to determine the outcome of the authorization request.

Disenrollment

The member is disenrolled from the Medi-Cal managed care plan after the transplant has been approved by either the DHCS Medi-Cal field office (unless the transplant is for a renal transplant to a member ages 21 and older), or the CCS program, where the member is under age 21. The disenrollment process is as follows:

- The health plan approves referral of the member to an approved transplant facility for evaluation.
- The transplant physician performs a pre-transplant evaluation of the member and the member is considered a suitable candidate for transplant.
- The transplant physician submits a TAR to the Medi-Cal field office or a Service Authorization Request (SAR) to the local CCS program office for transplant procedure approval.
- The health plan submits the disenrollment request, accompanied by the approved TAR or CCS authorization, to the HCO contractor for DHCS.

When the disenrollment request is approved, the effective date of disenrollment is retroactive to the beginning of the month in which authorization is given by the Medi-Cal Field Office or CCS program office for the transplant. Services performed during this month are billed to DHCS on an FFS basis.

The Medi-Cal Member Services Department notifies the member of the disenrollment.

If the member is not considered an appropriate candidate for transplant by the transplant center, the transplant center informs the member of the determination, and the care manager continues to coordinate all care with the member's PCP.

Kidney Transplants

All members ages 21 and older requiring kidney transplants remain members of the health plan. The referral process is the same as for the other types of organ transplants. When the complete set of medical records is received, the transplant packet is forwarded to a Medi-Cal medical director for review. A determination is made within seven business days. If the request is approved, the care manager issues authorizations and develops a care management plan. The transplant center notifies the care manager when the member is admitted for transplant. The care manager, in turn, notifies a concurrent review nurse, who certifies payment for the inpatient days of stay based on medical necessity.

Prior to discharge from the hospital, the care manager issues authorizations for immediate follow-up medical care requested by the transplant center. The transplant center case manager completes a final report and submits the information to the member's PCP within five days of discharge. This information is intended to assist the PCP in issuing ongoing care referrals.

If the request for a kidney transplant is not approved, the care manager documents it and notifies the member, provider and the transplant center of the review decision. The care manager then provides the member with information about the appeal procedure.

Referral to CCS

Medi-Cal members under age 21 with CCS-eligible conditions who require major organ transplants are referred to CCS. Care managers assist the PCP in ensuring 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 the health plan's coverage responsibilities.

Member Identification

Members requiring refugee health services may be identified through:

- Community-based organizations.
- Initial health assessments.
- Inpatient admissions (concurrent review).
- PCPs and specialists.
- Care management services.
- Emergency room and urgent care use information.
- Public programs coordination, Medi-Cal Member Services, Health Education or Provider Relations departments, or Medi-Cal Provider Services Center.
- 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, the health plan 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 telephone number, date of birth, gender, ethnicity, and marital status).
- Locating information (employer, work address and telephone 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

Public programs administrators maintain regular contact with the Refugee Health Medical Assistance Program.

Health Care Services staff is available to provide assistance with coordination of care if indicated by the member's condition or requested by the PCP or the public programs administrators.

Out-of-Network Coordination

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

Regional Center Coordination

Regional centers are private, non-profit corporations under contract with DDS. Their purpose is to provide or coordinate services and support for individuals with developmental 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, the health plan covers genetic counseling and other prenatal genetic 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 developmental screens; the results of developmental assessments and psychological evaluations; and other diagnostic tests.

When the Medi-Cal Health Care Services 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 Health Care Services 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, the Health Care Services 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.
- 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 the provision of direct medical or health care services, but do provide care management and 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.

Chapter 7 – Public Health Waiver Programs

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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 the health plan 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 the health plan.

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 the plan 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 6.2, 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 the health plan or the primary care physician (PCP) are handled by the health plan's public programs administrators. During any such period, the Health Care Services staff and the PCP or specialty provider continue to coordinate the care of the member.

AIDS Waiver Program

The California Department of Public Health's (CDPH's) AIDS Waiver program provides Medi-Cal fee-for-services (FFS) home and community-based services to members with AIDS or symptomatic HIV disease who would otherwise require placement in a skilled nursing facility (SNF) or who are at increased risk for this type of placement. The AIDS Waiver program is not covered by the plan but is paid for by FFS Medi-Cal. These CDPH FFS services support home-based care and coordinated care to improve health and prevent costly hospitalizations for members with HIV/AIDS.

Eligibility

Members must meet the CDPH's AIDS Waiver program eligibility requirements to participate through the health plan. Managed care members are not required to disenroll from the health plan in order to enroll in the Medi-Cal FFS AIDS Waiver program. To qualify, members with AIDS or symptomatic HIV disease must meet the CDPH's criteria:

- Be enrolled in Medi-Cal.
- 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 care manager to be at the SNF level of care and score 60 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 AIDS Waiver program prior to use of AIDS 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.

AIDS Waiver Program Care Management

The CDPH's AIDS 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 AIDS Waiver program services subcontractors.

The CDPH's Office of AIDS contracts with agencies throughout California to administer the AIDS Waiver program and provide nurse care management services. These agencies subcontract with licensed providers for services.

CDPH's AIDS 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. AIDS 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 AIDS 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, Health Care Services staff or both inform eligible members about the AIDS 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 Health Care Services or public programs staff initiates a referral. The CDPH Office of AIDS assesses the member based on the CDPH's AIDS Waiver program criteria for enrollment eligibility.

With the member's consent, the PCP or Health Care Services 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 AIDS Waiver program, the Health Care Services staff concurrently institutes a care management plan and coordinates with the member's PCP.

The member's PCP and Health Care Services 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, 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 Health Care Services staff contacts the Medi-Cal Member Services Department to initiate the disenrollment. The Health Care Services staff is responsible for authorization of services and coordination of the member's medical care until the member enters the AIDS 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 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. The services provided under the HCBS Waiver program for persons with developmental disabilities are not covered under the plan's Medi-Cal contracts.

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. There are four types of care settings in which specialized services may be delivered through the DDS HCBS Waiver program:

- Member's family's home.
- Local intermediate care facility (ICF), licensed as an ICF for the developmentally disabled (DD).
- Local habilitative developmental disability care facility, licensed as an ICF for the developmentally disabled-habilitative (DD-H).
- Local nursing developmental disability care facility, licensed as an ICF for the developmentally disabled-nursing (DD-N).

The regional center service coordinator is responsible for determining the DDS HCBS Waiver setting that is best for the eligible developmental 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 participating PCP continues to provide all primary care and other medically necessary services.

Eligibility

The health plan's utilization management (UM) staff monitors and reviews inpatient stays to, among other things, identify members who may benefit from a DDS-administered HCBS Waiver program. The health plan works to ensure that potentially eligible members are referred in a timely manner.

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 health plan coordinates with the inpatient facility discharge planner and care manager to refer the member to a licensed and Medi-Cal certified home health agency for evaluation. The home health agency care managers evaluate the member's health care needs and whether they can be met in the member's home.

Coordination of Services

Once the health plan determines a member may meet the requirements for participation in the DDS-administered HCBS Waiver program, the plan 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. The health plan 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, the plan coordinates services with the PCP and regional center service coordinator.

If the member does not meet the criteria for the waiver program or if placement is unavailable, the PCP continues to manage care and provide all medically necessary care to the member.

Home and Community-Based Services Waiver Administered by In-Home Operations

Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment, and those at risk of life-threatening occurrences, requires close coordination between the health plan and the HCBS Waiver program administered by the In-Home Operations (IHO) intake unit within the Department of Health Care Services (DHCS). By providing in-home care, this program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met.

HCBS Waiver Programs

The DHCS Medi-Cal In-Home Operations Division administers three HCBS waiver programs for chronically ill members:

- The In-Home Medical Care (IHMC) Waiver is designed for Medi-Cal beneficiaries who, in the absence of the waiver, would be expected to require at least 90 days or more of acute hospital care. This waiver is for individuals who have a catastrophic illness, may be technology-dependent and have a risk for life-threatening occurrences.
- The Nursing Facility (NF) Waiver is designed for persons who are physically disabled or aged and would require at least 180 days or more of NF care. The level of service under NF subacute care includes adult and pediatric subacute care.
- The NF A/B Waiver is designed for persons who are physically disabled and would be expected to require at least 365 days or more of nursing facility care. This waiver includes NF A (Intermediate Care Facility) and B (Skilled Nursing Facility).

The IHO-administered HCBS Waiver program provides long-term care to recipients. If a member meets the criteria for HCBS services and is accepted into the waiver program, the member is disenrolled from the health plan and enrolled in the Medi-Cal FFS program.

Eligibility

The Health Care Services Department monitors and reviews all inpatient stays for proper use and to identify members who may benefit from one of the three HCBS Waiver programs. The Health Care Services Department also works to ensure that potentially eligible members are referred to the IHO intake unit in a timely manner. A Medi-Cal or waiver service provider must make actual requests for HCBS services.

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 Health Care Services Department will coordinate 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.

HCBS Team Conference

IHO intake unit staff is responsible for processing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) private-duty nursing and pediatric day health care requests. This unit is also responsible for reviewing all new requests statewide for HCBS Waiver services. Upon receipt and review of the HCBS application, the request for HCBS Waiver services is forwarded to the appropriate regional office for completing the intake process and ongoing administrative case management. Provision of waiver services depends on concurrence of the member, guardian or authorized representative, PCP, and a licensed and Medi-Cal-certified home health agency. DHCS requires that each party sign a letter of agreement to ensure that all participants understand their roles and responsibilities and the benefits and limitations of the waiver.

Home Health Care Agency Responsibilities

The home health care agency prepares all necessary letters of agreement and the Treatment Authorization Request (TAR). Home health care agencies are encouraged to identify the waiver recipient by highlighting IHO Waiver Recipient in the provider address section of the TAR. The home health care agency submits the information to IHO. The home health care agency sends a copy of the documentation to the Health Care Services Department for tracking and follow-up.

IHO Unit Responsibilities

The IHO unit staff assesses the member's medical condition to determine whether waiver services are necessary and which waiver program (IHMC or SNF) is more appropriate.

IHO reviews the request for necessity and suitability and assists the waiver participant and provider with documentation. IHO evaluates the level of care, whether DME is required, medication, nursing hours, cost-effectiveness, and the sufficiency of the home for the member's health and safety needs. Final approval is subject to review by a Medi-Cal physician and IHO headquarters in Sacramento.

IHO may authorize:

- Home health care management, consisting of weekly registered nurse (RN) supervisory services.
- Skilled nursing care, which are hourly nursing services provided by RNs or licensed vocational nurses (LVNs).
- Home health aide services, which are services provided by a certified person and supervised by an RN or LVN.
- Modification of the home, consisting of minor changes that enable the member to receive care at home.
- Reimbursement for utility costs incurred due to continuous operation of life-sustaining equipment.

IHO may approve services up to 24 hours per day if prescribed by the member's PCP.

Coordination of Care

Upon acceptance by the IHO intake unit into a local home health agency, the Health Care Services Department initiates the member's disenrollment process and facilitates an orderly transfer of medical service responsibility from the health plan to the Medi-Cal FFS program.

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 (SNF). 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.
- Be certifiable for placement in a SNF.
- Live in a county with an MSSP site and be within the site's service area.
- Be appropriate for care management services.
- Be 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.

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Chapter 8 – Health Care Management

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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. The plan's care management program involves identifying medical need and allocating resources.

The plan 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, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, 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.

Care management, continuity of care, utilization management, credentialing, and quality improvement programs are outlined in this chapter.

Identification of Potential Care Management Recipients

Members are referred by the PCP or specialist for individual medical care management services for high-risk medical conditions. The following list of medical conditions represents the type of conditions that must be referred for comprehensive care management:

- Multiple trauma with acute estimated length of stay (ELOS) over 10 days.
- Severe neurological diseases that are chronic and degenerative (for example, amyotrophic lateral sclerosis (ALS)).
- Complex multi-diagnostic cases.

In addition, Medi-Cal members with the following medical conditions must be referred to care management for referral to the appropriate state or county program:

- All transplant cases (excluding corneal and kidney for members over age 21).
- Multiple congenital birth defects.
- Pre-term births or pre-term births 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 the age of three with speech/language delay.

Referral to Care Management

The referral is made to the health plan care management intake coordinator in the Health Care Services Department. Most cases are identified through the inpatient concurrent review process, but referrals are accepted from any source. 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.

Palliative Care Services

Prior authorization (PA) is required for the initial enrollment in the palliative care program. The plan monitors the member on an ongoing basis during care. Eligible members may continue to receive covered benefits and services while receiving palliative care for Medi-Cal managed care members, regardless of age, who are diagnosed with cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and liver disease, and have a life expectancy of 12 months or less, and with a continued decline in health status, whereby the emergency department (ED) and hospital are used to manage the illness.

Members receiving palliative care may transition to hospice care if they meet the hospice eligibility criteria; however, palliative care benefits are not available once the patient has transitioned to hospice.

Palliative care services provide an extra layer of support in addition to existing benefits. The plan's palliative team and the plan's approved palliative care providers collaborate with other members of the health care teams and services to coordinate palliative services with ongoing existing medical services. Providers can refer an eligible CalViva Health Medi-Cal member to the palliative care program via email to Cindy.tatu@healthnet.com.

PCP Responsibilities

- The PCP continues to be the principal person responsible for directing the member's care. The health plan 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 to expedite health services for the member.
 - Participating as a member of the health care team in the member's care management plan.
 - Attending care conferences to evaluate the member's progress and modify the care plan, if necessary.
 - Maintaining complete documentation in the member's medical record.

Care Management for Carve-Out Services

Some catastrophic conditions have been carved out of the health plan and are not covered by the health plan under its Medi-Cal managed care contract with the DHCS. Transplant cases (excluding corneal transplants and kidney transplants for members over 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.

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 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. 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 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 services.
- Forwarding summaries of pertinent medical findings to specialists.
- Documentation of services provided by specialists in the member's primary care medical record.
- Monitoring of members with ongoing medical conditions.
- Notifying the health plan 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 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.

CalViva Health 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 the health plan all Medi-Cal members who have been referred to public health programs, excluding those referred for sensitive services, such as HIV testing and counseling, family planning, and alcohol and drug abuse treatment. Notification to the Health Care Services 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 Hospital Notification Unit.

Missed Appointments

Members may miss appointments due to 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 – telephone call to member (or a written letter must be sent if the member does not have a telephone).
- 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 telephone).
- 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 attempts must be reported to the health plan's public programs administrators.

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 telephone 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, member or health plan.

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 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

The health plan is required to comply with the following standards for UM decisions (refer to the 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 telephone 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 telephone 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.

Clinical Criteria for Utilization and Care Management Decisions

To determine medical appropriateness, the health plan 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, the health plan uses criteria set forth in applicable sections of Title 22 of the California Code

of Regulations, Title 17 MMCD policy letters, DHCS Manual of Criteria for Medi-Cal Authorization (MOC) and the Hayes Medical Dictionary. These criteria are used to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying or denying requests for services.

The health plan also uses InterQual Care Planning Criteria, along with other company-wide evidence-based medical policies, which are approved and updated by the Medical Advisory Council (MAC). The health plan'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, the health plan considers Title 22 to prevail. The health plan makes available its National Medical Policies on the provider website.

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 CalViva Health 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 policies regarding UM decisions, refer to the Medi-Cal provider operations manuals online in the Provider Library.

Continuity of Care Assistance

The health plan offers continuity of care assistance to newly enrolled Medi-Cal members for up to 12 months in certain situations. 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 non-participating 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 provider after that provider leaves the plan'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 non-participating 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 the health plan has determined make the provider ineligible to continue providing services to CalViva Health members. Cases are considered for continuity of care assistance based on evidence of an ongoing relationship with the non-participating provider or terminating provider and plan benefits. The following continuity of care duration criteria applies:

- Pregnancy – for the duration of the pregnancy and the immediate postpartum period (45 days).
- Surgery or procedure scheduled by a provider that is authorized by the plan – as part of a documented course of treatment recommended to occur within 180 days of the provider's termination date for current CalViva Health members or effective date of coverage for newly enrolled 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. Completion of covered services for a serious chronic condition shall not exceed 12 months from the provider termination date or 12 months from the effective date of coverage for newly enrolled Medi-Cal members.
- 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 CalViva Health members, which may exceed 12 months from the provider termination date or 12 months from the effective date of coverage for newly enrolled Medi-Cal 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 the health plan. When this occurs, the health plan initiates the process of reviewing the request within five business days after receipt of the request.

The health plan 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 CalViva Health Member Services Department.

Quality Improvement

The 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 population's demographics and health risk characteristics, as well as current national, state and regional public health goals. The QI program impacts the following:

- CalViva Health members in all demographic groups and in all service areas in which the health plan 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 the health plan.
- 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 the health plan, 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); In-Home Support Services (IHSS); Community Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP); 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.

QI Department

The QI Department establishes programs to meet 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 certification, and medical record audits, along with any necessary follow-up quality action plans. The health plan 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.

QI Audits of Medi-Cal Providers

Facility Site Review

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 certifications program as part of the initial credentialing process. The full scope site review includes the facility site review (FSR), physical accessibility review and the medical record review (MRR). Reaudits are conducted a least every three years as required by DHCS.

In an effort to decrease duplicative FSRs and minimize the disruption of patient care at provider offices, all Medi-Cal managed care health plans are required to collaborate in conducting FSRs. 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 threshold scores on an FSR or MRR are forwarded to the Credentialing Committee for administrative termination. 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 may also audit a random sample of provider offices to ensure they meet DHCS standards.

Medical Record Audits

The health plan's FSR compliance department conducts periodic MRRs to measure provider compliance with current DHCS medical documentation standards. In an effort to decrease duplicative MRRs and minimize the disruption of patient care at provider offices, CalViva Health and all other Medi-Cal managed care health plans are required to collaborate in conducting MRRs. 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 CAP when necessary. The responsible plan shares the audit results and CAP with the other participating health plans. DHCS reviews the results of MRRs and may also audit a random sample of provider offices to ensure that they meet DHCS standards.

Disease Management Programs

The *Be In Charge!*SM Disease Management Program provides disease-specific management for members with chronic conditions. 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. The plan 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

- The Health Education Department educates 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:
- Toll-free Health Education Information Line – Members or parents of child members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, and exercise. These materials are available in threshold languages.
- Tobacco Cessation Program – On behalf of CalViva Health, Health Net has partnered with the California Smokers' Helpline. This program offers free telephone counseling, self-help materials and online help in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese) to help members quit smoking and stay tobacco-free. In addition, specialized services are available to individuals who chew tobacco, teens and pregnant members at (1-800-NO-BUTTS).
- Fit Families for Life – *Be In Charge!*SM Weight Control Programs. Members may access a five-week, home-based nutrition and physical activity program, educational resources and access to the Breastfeeding and Nutrition Support Line for answers to general nutrition questions and lactation support. Obese members are eligible to receive telephonic coaching support and text messages.
- Health education classes – Members may access health education classes on a variety of health topics, such as diabetes, asthma, healthy eating, fitness, and prenatal care.
- Pregnancy Matters® – Pregnant members receive educational resources and telephonic support through the Breastfeeding and Nutrition Support Line 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.

- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to community classes to learn how to maintain a healthy heart.
- Electronic health education – Teens from age 13 and adults may participate in electronic health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and seek preventive health care services.
- Staying Healthy Assessment (SHA) – Providers need to complete a SHA to prioritize individual health education needs of their assigned members related to lifestyle, behavior, disability, environment, and cultural and linguistic background.

Providers may call the Health Education Department to order health education materials and refer members into health education programs and services.

Credentialing and Recredentialing

The credentialing program establishes criteria and reviews professional qualifications for approving new and evaluating continuing participating practitioners. Practitioners are evaluated for compliance in accordance with the health plan, federal and state regulatory requirements, and accrediting entity standards. Practitioners must be credentialed prior to providing health care services to health plan 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 the plan's standards for participation requirements are accepted or retained in the plan's provider network. The credentialing process is administered by the health plan or subcontracting health plans, agencies or PPGs to which credentialing responsibilities have been delegated in accordance with plan criteria. The health plan does not authorize these entities to grant temporary privileges. The plan retains the right to deny, approve, suspend, limit, or terminate a practitioner agreement through the credentialing process.

Chapter 9 – Claim Billing and Encounter Information

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Claim Billing and Encounter Information

Providers may obtain claims reimbursement more efficiently by becoming familiar with the health plan's claims procedures. This chapter covers claims, billing and encounter reporting procedures. Processes for tracing the status of a claim or requesting a claim payment adjustment are described. Provider responsibilities for coordination of benefits (COB) and third-party tort liability are explained. This chapter also provides detailed information regarding 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 order, state or administrative hearing, county error in eligibility, Department of Health Care Services (DHCS) order, reversal of appeal decision on a Treatment Authorization Request (TAR), or if other coverage is primary.

Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims from fee-for-service (FFS) providers are submitted to the Electronic Data Interchange (EDI) Claims Department. An authorized vendor may be used for electronic claim submission. The health plan contracts with TransUnion Healthcare to provide claims clearinghouse services for claims submission. Contact the EDI Claims Department to establish electronic claims submission or for more information.

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 member and provider receive the other coverage's *Explanation of Benefits (EOB)*.

When the provider learns that a 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 check or *EOB* with the claim to the health plan.

COB Payment Calculations

- As the payer of last resort, the health plan's Medi-Cal plan coordinates benefits. In order for the plan 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.

Dual Coverage through Two Plans

Dual coverage refers to members that are covered under two health plans. Claims must be submitted to the primary plan first. The Medi-Cal plan is the secondary coverage under COB rules. The secondary claim must be submitted with the primary remittance advice, identification and group numbers, indicating the primary health plan ID number in the Other Coverage box.

Balance Billing and Other Billing Prohibitions

Balance billing is strictly prohibited by state and federal law and the *PPA*. Balance billing occurs when a participating provider bills a member for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for such services denied by the health plan. Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept the health plan'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, individual health education behavioral assessment tools/staying healthy assessment (IHEBA/SHA), health histories, patient consent forms, and medical record transfer forms.

Participating providers are prohibited from charging a 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 Medi-Cal provider operations manuals in the Provider Library.

Encounter Reporting

Reporting of encounter data is extremely important. The health plan is required to provide encounter data to regulatory agencies. Default enrollment is also based on complete and accurate submissions of encounter data. Providers must report services on a per member, per visit basis, rather than a monthly summary. An accounting of all services rendered by date and member must be submitted to the health plan. The encounter data should be submitted via electronic transmission in the HMO's Western Region HMO/Information Services Standards (HMOIS) format, UB-04 or the ANSI 837 5010 X12 format. Encounter records must include the same data elements as would be required on a FFS claim form. An authorized EDI vendor or clearinghouse may also be used for encounter reporting purposes.

The health plan does not accept encounter and encounter summary reports on paper. Only electronic encounters should be forwarded.

DHCS dictates that the plan report services within 90 days from the month of service. Providers are required to report services according to the terms of the *PPA*.

PPGs are required to submit an electronic encounter file once a month (at a minimum).

All encounter reporting must identify members by their ID number. This number is on each member's ID card. Submission of encounter data without the member ID number is not acceptable and will be returned for correction.

Providers who require assistance with Medi-Cal encounter submissions or have questions regarding encounter data requirements may contact the Encounter Department.

Reimbursement Methods

For services provided to Medi-Cal members, the health plan 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, the health plan uses the DHCS Medi-Cal fee schedule rates.

For both participating and non-participating providers, the health plan 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 percent.
- Immunizations and injectable medications, including chemotherapy drugs, 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 Medi-Cal contracts, the health plan 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.

The health plan and its participating providers are required to assist DHCS in pursuing the state's right to reimbursement from such recoveries. The health plan is required to notify DHCS within 10 days of the discovery of such cases. On request from DHCS for information, the plan must provide additional information within 30 days of the request. Individual providers are obligated to help the plan provide the additional information on request.

Provider Responsibilities

Providers are responsible for the following:

- Notifying the health plan in writing of all potential and confirmed third-party tort liability cases involving a Medi-Cal member.
- Notifying the plan if the provider receives any requests by subpoena from attorneys, insurers or members for copies of bills.
- Supplying the plan with copies of the request, copies of documents released as a result of the request, and providing the name, address and telephone number of the requesting party. Notifications should be mailed to:

Medi-Cal TPL
Recovery TPL Department
11971 Foundation Place, Building C
Rancho Cordova, CA 95670-4502

In all third-party tort liability cases, bill the health plan as usual, and give all details regarding the injury or illness. The health plan 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 CalViva Health and enrollment in the PPG before providing care. If the PPG does not follow the required steps for verification of eligibility and enrollment, the plan 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 the plan (refer to page 9.1 for exceptions).

Providers Enrolled in the 340B Program

The plan 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 Appeal Procedures

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Grievance and Appeal Procedures

The grievance and appeals procedures offer recourse to members and providers who are dissatisfied with any aspect of service from the health plan or its participating providers. Members may file grievances whenever they have complaints 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 the health plan's policy for resolving complaints.

Member Grievance and Appeal Procedures

Member Grievance Procedure

A grievance is any oral or written expression of dissatisfaction made by the member or the member's representative about any matter other than an adverse benefit determination. A member, or their physician or other representative, may file a grievance on behalf of the member. 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. The health plan investigates these complaints and resolves them.

Members are encouraged to attempt to discuss concerns with their provider first. 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 at any time. To submit a grievance in writing, members may contact the Medi-Cal Appeals and Grievance Department. To submit a verbal grievance, members may contact the Medi-Cal Member Services Department. Members may obtain a Member Grievance/Complaint form from their provider's office or they may contact the Medi-Cal Member Services Department for assistance.

Once the Medi-Cal Appeals and Grievance Department receives the member grievance, it is sent to a grievance coordinator for investigation. The health plan 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 are sent to the member.

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 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 the health plan to consider.

Appeal Resolution Process

When the 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. A decision is made within 30 days of receipt of a standard appeal and within 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 the health plan 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 by phone or in writing from the California DSS only after receiving an NAR and within 120 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.

Provider-Initiated Member Appeals

A provider may submit an appeal on behalf of the member when the member is challenging a denial for a prior authorization request or a service.

These appeals are considered member appeals, not provider appeals. They are processed in the same manner as an appeal submitted by a member:

- Health plan processes the appeal, not the subcontractor.
- Health plan's decision is final. There is no second-level appeal.
- Providers do not have the option of requesting a hearing with DSS.

Member Appeals Address

CalViva Health Member Appeals and Grievance 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 of care. 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 Medi-Cal Provider Services Center. 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.

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, the health plan sends 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 Medi-Cal Provider Services representative who receives the grievance forwards the information to a 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 regional medical director responsible for the region for review and resolution of the grievance.

The 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).
- 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 the health plan, 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 Medi-Cal Member Services Department.

Provider Dispute and Appeal Procedures

The 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 the health plan.
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which the health plan needs more information in order to process the claim.
- Challenge a request by the health plan for reimbursement for an overpayment of a claim.
- Seek resolution of a billing determination or other contractual dispute with the health plan.
- Appeal a PPG's written determination following its dispute resolution process when the dispute involves an issue of medical necessity or utilization review, to the health plan for a *de novo* review, provided the appeal is made within 60 business days of the written determination.

Additional processes depending on the provider's contractual relationship with the health plan include challenging:

- Capitated PPG liability for medical services and payments that are the result of health plan decisions arising from member grievances, appeals and other member services actions.
- Capitation deductions that are the result of health plan decisions arising from member billings, claims or member eligibility determinations.

The health plan does not charge providers of service who submit disputes to the Medi-Cal Appeals Unit for processing provider disputes and does not discriminate or retaliate against a provider who uses the 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 10.1, Member Appeal Procedure, for more information).

Submission of Provider Disputes

The health plan accepts disputes, including appeals, from participating providers if they are submitted within 365 days of receipt of the health plan's decision (for example, denial or adjustment), except as described below. If the provider does not receive a decision from the health plan, 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 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 telephone 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*.

A provider dispute that is submitted on behalf of a member is considered a member appeal and is processed through the member appeal process. Providers may submit member appeals using the Provider Dispute Form. Submit disputes to the Medi-Cal Provider Appeals Unit. Providers who participate under a capitated agreement with a PPG must submit disputes to the PPG that processed the claim.

Disputes Submission Addresses

Submit provider disputes concerning a medical claim as indicated below.

Capitated Provider First-Level Disputes

These must be sent to the PPG's claims billing address.

FFS Providers and Capitated Provider Second-Level Disputes

Medi-Cal Provider Appeals Unit

PO Box 419086

Rancho Cordova, CA 95741-9086

Acknowledgment and Resolution

The health plan 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 the health plan as part of the claims adjudication process, unless the plan returned the information to the provider.

The health plan resolves each provider dispute within 45 business days following receipt and sends the provider a written determination stating the reasons for the determination.

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 obtain payment calculation clarification.
- Resubmit contested claims with the missing information requested by the health plan.
- Submit a corrected claim (additional charges previously not submitted).
- Clarify member responsibility.

Submission of Provider Inquiries

For routine claim follow-up, providers may use the State Health Programs (SHP) Provider Inquiry Spreadsheet, available in the Medi-Cal Provider Library. Use this spreadsheet for resubmission of contested claims with missing information (requested individual claim documents), submission of corrected billing (additional charges previously not submitted), inquiries regarding claim status and payment calculation clarification, and assistance in determining member responsibility.

Submit provider inquiries via fax or email to:

Medi-Cal Provider Services Center

Fax: (818) 676-5387 or (818) 676-5161

Email: HNMedi-Cal.ClaimsInquiry@healthnet.com

Requests

If a participating provider believes that a claim was processed inaccurately and wants to request an adjustment, he or she may resubmit the claim to the plan, requesting reconsiderations of the claim by following the provider dispute resolution process.

Appeal Status

Providers can contact the Medi-Cal Provider Services Center or Medi-Cal Member Services Department to check the status of a dispute or appeal.

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.

Child Health and Disability Prevention (CHDP) Program. 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) Services and the Prenatal Guidance Program.

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, CHDP, 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) Program. An initial, periodic or additional health assessment of an eligible individual under age 21 provided in accordance with the requirements of the CHDP program as provided in 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. The level of medical or surgical treatment and supplies or behavioral health care adequate for the diagnosis and treatment of disease, illness or injury.

Member. An eligible beneficiary who has enrolled in a CalViva Health 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 and CalViva Health 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 CalViva Health, or indirectly through another entity, such as another participating provider, to provide covered services.

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 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 diseases 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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