2026 Medi-Cal Operations Guide

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

Contractual Arrangements and Applicability to 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.

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a DHCS initiative to address the social determinants of health and improve health equity statewide. To support the CalAIM initiative, services listed below are available to eligible Medi-Cal members.

- **Enhanced Care Management (ECM)** – ECM offers extra services at no cost to members who have complex needs that make it hard to improve their health. This includes access to a single Lead Care Manager who provides comprehensive care management and coordinates their health and health-related care and services. The Plan contracts with community-based ECM providers who have experience serving the ECM populations of focus (see table on page 3), and expertise providing the core ECM services, to provide services to eligible members under the Medi-Cal ECM benefit.
- **Community Supports (CS) services** – There are 14 DHCS-approved CS services to address the needs of members – including those with the most complex challenges affecting health, such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs. Refer to the table on page 4 for detailed descriptions of the 14 CS services.
- **Doula services** – Doula services are considered preventive and provide support to members during pregnancy, birth and postpartum. This also includes pregnancies that end in stillbirth, miscarriage or abortion. Doulas do not diagnose medical conditions, provide medical advice, or clinical assessment, exam, or procedure. You can help connect members to local doulas listed in the provider directory or by calling member services for a list of local doulas.
- **Community Health Worker (CHW) services** – CHW services are considered preventive care services that provide health education and navigation services to help members get the care they need. CHWs are members of the community, such as community health representatives and non-licensed public health workers, including violence prevention professionals. You can connect members to local CHW organizations listed in the provider directory or by calling provider services for assistance.
- **Street Medicine** – The Street Medicine benefit covers up to the full array of services necessary to meet immediate needs of Medi-Cal members experiencing unsheltered homelessness. Services include but are not limited to, preventive services, and the treatment of acute and chronic conditions.

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

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

Enhanced Care Management Populations of Focus

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

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

Community Supports Services

CS services	Description
Housing Transition Navigation Services	Assistance with obtaining housing. This may include assistance with searching for housing or completing housing applications, as well as developing an individual housing support plan.
Housing Deposits	Funding for one-time services necessary to establish a household, including security deposits to obtain a lease, first month's coverage of utilities.
Housing Tenancy and Sustaining Services	Assistance with maintaining stable tenancy once housing is secured. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services to develop financial literacy.
Transitional Rent	Rental assistance to support connections to long-term housing.
Short-Term Post-Hospitalization Housing	Short-term residential settings for members to continue medical, psychiatric, and substance use recovery immediately after leaving an institution.
Recuperative Care (Medical Respite)	Short-term residential setting for members to recover from an injury or illness (including a behavioral health condition).
Respite Services	Short term relief provided to caregivers of members who require intermittent temporary supervision.
Day Habilitation Programs	Programs provided to assist members with developing skills necessary to reside in home-like settings, often provided by peer mentor type caregivers. These programs can include training on use of public transportation or preparing meals.
Assisted Living Facility (ALF) Transitions	Services provided to assist members with living in the community and avoiding institutionalization, whenever possible.
Personal Care and Homemaker Services	Services provided to assist members with daily living activities, such as bathing, dressing, housecleaning, and grocery shopping.
Environmental Accessibility Adaptations (Home Modifications)	Physical adaptations to a home to ensure the health and safety of the member. These may include ramps and grab bars.
Medically Supportive Food/Medically Tailored Meals	Meals delivered to the home that are tailored to meet members, nutrition-sensitive conditions, and specific nutrient needs. This service is not intended to respond solely to food insecurities.
Sobering Centers	Alternative destinations for members who are found to be intoxicated and would otherwise be transported to an emergency department or jail.
Asthma Remediation	Had a home check for asthma triggers in the past 12 months through the Asthma Preventive Services (APS) program that shows changes are needed.

CHAPTER 1 – WHO TO CONTACT

Resources for providers and members are described below, followed by a listing of phone 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 specialists in the Medi-Cal counties. Public programs specialists work to find strategies to improve health care delivery.

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

PROVIDER RELATIONS DEPARTMENT
The 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 DEPARTMENT
Medi-Cal Provider Services Department 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 for members, benefit information, claims, billing, complaints and grievances, and other provider inquiries.

INTERPRETER SERVICES
Interpreter services are offered to participating providers and members at no cost to ensure they have access to qualified interpreters trained in health care terminology, interpreting protocols and ethics, and to support common communication challenges across cultures. Members and providers may request an interpreter by calling 888-893-1569 (TTY:711).

Member Resources

HEALTH EDUCATION DEPARTMENT

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

HEALTH EQUITY DEPARTMENT

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

MEDI-CAL MEMBER SERVICES DEPARTMENT

The Medi-Cal Member Services Department handles phone 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.

Phone 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 Plan's policies and procedures, and changes in contractual, legislative and regulatory requirements through provider operations manuals, updates and letters.

provider.communications@healthnet.com

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.

888-893-1569

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

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

DELEGATION OVERSIGHT
The Delegation Oversight Department oversees participating providers and assists them in understanding and complying with Plan requirements and those of state and federal regulatory agencies.

Fax: 866-476-0311

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

800-322-6384

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

888-452-8609

DEPARTMENT OF MANAGED HEALTH CARE
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 Plan.

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
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.

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

ELIGIBILITY VERIFICATION
The Medi-Cal Provider Services Department 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.

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, waste or abuse by providers or members should be reported to the Fraud Hotline. Reports of suspected fraud may be made anonymously.

866-685-8664

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

800-576-6881

Armenian

800-840-5032

Cambodian

800-430-5005

Cantonese

800-430-6006

English and other languages

800-430-4263

Farsi

800-840-5034

Hmong

800-430-2022

Korean

800-576-6883

Laotian

800-430-4091

Mandarin

800-576-6885

Russian

800-430-7007

Spanish

800-430-3003

Tagalog

800-576-6890

Vietnamese

800-430-8008

TTY/TDD (hearing impaired)

800-430-7077

HEALTH CARE SERVICES

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

Prior Authorization
888-893-1569
Fax: 800-743-1655
provider.healthnetcalifornia.com

PHARMACY SERVICES

Providers must contact Pharmacy Services by phone, fax or mail to request prior authorization. Pharmacy Services is responsible for the review of prior authorization requests for medication covered under the medical benefit for CalViva Health Medi-Cal members.

800-867-6564, option 2
Fax: 833-953-3436

MedPharm
Attention: Prior Authorization
4191 East Commerce Way, Sacramento, CA 95834
Mailstop: CA4151-04-530

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 *PPA* may result in a denial of payment.

800-995-7890, option 2
Fax: 800-676-7969

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

833-888-893-1569 (TTY:711)

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

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

888-893-1569, open 24/7
Fax: 844-837-5947 or 800-281-2999

MEDI-CAL MEMBER APPEALS AND GRIEVANCES DEPARTMENT
PO Box 10348, Van Nuys, CA 91410-0348
Fax: 877-831-6019

MEDI-CAL PROVIDER APPEALS UNIT
Submit claims appeals to CalViva Health Provider Dispute and Appeals Unit at the following address:

PO Box 989881, West Sacramento, CA 95798-9881

MEDI-CAL PROVIDER SERVICES DEPARTMENT

The Provider Services Department assists providers with:

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

888-893-1569
Fax: 844-837-5947 or 800-281-2999

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

hnmedi-cal.claimsinquiry@healthnet.com

BEHAVIORAL HEALTH PROVIDER SERVICES

If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the PCP or their staff may contact the Plan for a referral to a behavioral health provider.

844-966-0298

NURSE ADVICE LINE

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

888-893-1569

QUALITY IMPROVEMENT

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

Cqi_dsm@healthnet.com

WEBSITE RESOURCES

The provider 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.healthnetcalifornia.com

CalViva Health's website offers additional information and other reference materials.

https://calvivahealth.org/providers/resources/

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: 877-779-0753
Facility.site.review@healthnet.com

Health Education

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

7625 N. Palm Ave., Ste. 107, Fresno, CA 93711
888-893-1569
Fax: 800-628-2704

Public Programs

The Public Programs specialists interact with public health departments and programs and with participating providers and DHCS in administering public health programs and services.

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

Public Health Agencies

CALIFORNIA CHILDREN'S SERVICES (CCS)
County Department of Health, California Children's Services (CCS)
1221 Fulton Mall, Fresno, CA 93721
559-600-3300
Fax: 559-455-4789

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

Fresno Community Based Adult Services
1060 Fulton St. Ste 105, Fresno, CA 93721
559-512-2227

Guardian Angels Adult Day Health Care
4835 E Mckinley Ave., Fresno, CA 93703
559-412-7642

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

Valley Adult Day Health Care Center, Inc.
1052 C St., Fresno, CA 93706
559-454-0386

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)
MCH Program County Department of Health, Community Health Department
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
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
888-638-7177

Sanger WIC Clinic
559-875-8639

Selma WIC Clinic
559-891-7097

SUBSTANCE ABUSE
559-600-6087

COMMUNITY-BASED ADULT SERVICES CENTER
To obtain information about the nearest CBAS center, go to the California Department of Aging website at www.aging.ca.gov.

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: 877-779-0753
Facility.site.review@healthnet.com

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

7625 N. Palm Ave., Ste. 107, Fresno, CA 93711
888-893-1569
Fax: 800-628-2704

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

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

Public Health Agencies

MEDI-CAL WAIVER PROGRAM
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

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
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

COMMUNITY-BASED ADULT SERVICES CENTER
To obtain information about the nearest CBAS center, go to the California Department of Aging website at www.aging.ca.gov.

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: 877-779-0753
Facility.site.review@healthnet.com

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

7625 N. Palm Ave., Ste. 107, Fresno, CA 93711
888-893-1569
Fax: 800-628-2704

Public Programs
The Public Programs specialists interact with public health departments and programs and works with participating providers and the DHCS in administering public health programs and services.
800-526-1898
Fax: 866-922-0783

Public Health Agencies

MEDI-CAL WAIVER 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

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
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

COMMUNITY-BASED ADULT SERVICES CENTER
To obtain information about the nearest CBAS center, go to the California Department of Aging website at www.aging.ca.gov.

CHAPTER 2 – ENROLLMENT AND DISENROLLMENT

Confusion about Medi-Cal managed care eligibility criteria and enrollment processes can hinder provision of health services to eligible Medi-Cal beneficiaries. This chapter describes the processes for enrollment and disenrollment, auto-assignment of a member to a 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:
    - Medi-Cal Waiver.

- Assisted Living Waiver.
- In-Home Medical Care Waiver.
- Nursing Facility/Acute Hospital Waiver.

NOT PERMITTED TO ENROLL

Medi-Cal beneficiaries who meet the following criteria are not permitted to enroll in a Medi-Cal 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 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 most Medi-Cal beneficiaries. The enrollment packet contains provider directories, a health plan comparison chart, enrollment instructions, a Medi-Cal Choice form, and a Medi-Cal Choice booklet.

MEDI-CAL CHOICE FORM

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

HEALTH PLAN ENROLLMENT ASSISTANCE

The beneficiary may contact the Medi-Cal health plan of choice for more information about the plan or PCP code. For questions – or assistance in connecting with the HCO enrollment contractor to submit the choice via phone – the beneficiary can call the CalViva Health Enrollment department at 877-618-0903.

AUTO ASSIGNMENTS TO THE HEALTH PLAN

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

PCP SELECTION CRITERIA

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

the Plan, if the PCP is available.

If the member has a doctor they want to keep, or if the member wants to find a new PCP, they can go to the Provider Directory for a list of all PCPs and other providers in the Plan's network. The Provider Directory has other information to help the member choose a PCP. If the member needs a Provider Directory, the member can call the Member Services Department at 888-893-1569 (TTY or 711). The member may also find the Provider Directory at www.calvivahealth.org/providers/provider-directory/.

IDENTIFICATION CARD AND MEMBER MATERIAL DISTRIBUTION

The 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. TheID 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 phone number of the member's assigned PCP or federally qualified health center (FQHC)/rural health clinic (RHC), if applicable
5. Effective Date with PCP – Date the member was assigned to the PCP or FQHC/RHC, if applicable
6. Copayments – Out-of-pocket expense the member is required to pay for covered services (varies by plan)
7. Pharmacy Information – Contact and claims information for prescription medication processing vendor
8. Issue Date – Date the ID card was issued
9. Enrollment Date – Date the member was enrolled with CalViva Health
10. Important Phone Numbers – CalViva Health contact phone numbers

MEMBER IDENTIFICATION NUMBER

The Plan uses the 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.

Disenrollment of a member is mandatory when:

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

PROVIDER REQUESTS TO DISENROLL A NON-COMPLIANT MEMBER

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

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

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

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

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

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

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

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

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

Formal letter and all supporting documents must be faxed or mailed to:

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

Eligibility Reports

The Plan generates eligibility reports twice a month to provide information about member assignments to PPGs. The 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 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 portal at provider.healthnetcalifornia.com.
- CalViva Health Provider Services at 888-893-1569.
- Affiliated Computer Services (ACS).
- 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 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 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.

CHAPTER 3 – ACCESS TO CARE

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

Primary Care Access Standards

APPOINTMENTS AND REFERRALS

Members are instructed to call their 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 STANDARDS

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

Medical Care Appointment Access Standards

Type of care	Standard
Emergency care	Immediately
Urgent care visit with a PCP or specialist (no prior authorization)	Appointment within 48 hours of request
Urgent care visit with a PCP or specialist (requiring prior authorization)	Appointment within 96 hours of request
Non-urgent/routine care appointment with a PCP (includes OB-GYN acting as	Appointment within 10 business days of request
Non-urgent care appointment with a specialist (includes OB-GYN specialty	Appointment within 15 business days of request
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Fresno, Kings and Madera counties: Within 14 calendar days of request.
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues. Appropriate after-hours emergency instructions
In-office wait time for scheduled appointments (PCP and specialist)	Not to exceed 30 minutes
Provider office phone callback for non-urgent issues during normal business hours	Provider callback within 1 business day
Phone answer time at provider's office	Within 60 seconds

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

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

The following access standards also apply:

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

INTERPRETER SERVICES

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

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

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 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 online and printed provider directory and made available to the Medi-Cal Member Services Department. The provider directory assists members in selecting a PCP who can best serve their health care needs.

AFTER-HOURS ACCESS

The Plan requires physicians, or an RN under physician supervision, to maintain 24-hour phone coverage seven days a week through their answering service or 24-hour on-site medical care for members.

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 phone calls and pages within 30 minutes.

EMERGENCY PHONE NUMBERS

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

Access to Confidential and Sensitive Services

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

FREEDOM OF CHOICE

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

SENSITIVE SERVICES

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

COVERAGE AND SERVICES

Members may access sensitive services in a timely manner and without barriers. Prior authorization is not required for access to certain services. Members may access most sensitive services from any qualified provider, in- or out-of-network, except obstetrical care for pregnancy. 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 Plan's coverage responsibilities. These services are covered, administered and paid for by sources other than the Plan. The 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

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

Nurse Advice Line

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

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

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

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

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

Emergency and Urgent Care

Emergency services are covered under the CalViva Health Plan in the United States, Canada or Mexico.
A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) could expect it to result in any of the following:

- Serious risk to your health
- Serious harm to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious risk in cases of a pregnant person in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery
  - The transfer might pose a threat to your health or safety or to that of your unborn child

Emergency services means covered inpatient and outpatient services that are:

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

URGENT CARE

Urgent care is required for those medical conditions that do not fit the definition of emergency but require the member to receive treatment within 48 hours.

PHONE ASSESSMENT

Phone assessment of member health problems and follow-up may only be performed by licensed staff (physicians, RNs 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 services are delivered based on need and an established care plan, offering a bundle of services during a service day. The number of days per week that members receive services is based on medical criteria and is included in their CalViva Health-approved individual plan of care (IPC). Services include, but are not limited to:

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

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

REFERRAL PROCESS

Participating providers, case managers, RNs, and licensed social workers who believe a CalViva Health member may benefit from the CBAS program must request a face-to-face assessment by submitting the request on the Plan's provider portal or by submitting the CBAS Treatment Request Form via fax to 833-581-5908. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References*. The Plan may forgo a face-to-face review if it is determined that the member is clinically eligible for CBAS and needs an expedited start date.

To submit a request for an assessment, go to the enrollee's profile and select *Assessments*. Click *Fill Out Now!* next to CBAS Treatment Request to initiate a face-to-face assessment and arrange for transportation to and from the center for assessment.

The plan's contracted vendor completes an initial face-to-face assessment using the CBAS Eligibility Determination Tool (CEDT) 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 or notification of services and number of days per week the member is eligible for services.

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

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

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

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

Fresno, Kings and Madera counties fall within the rural and small counties standard.

Mental Health Services

CalViva Health members obtain the following mental health services:

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

Members do not need to contact their PCPs, PPGs or attending physicians to request referrals for mental health care office visits. Members may obtain mental health office visits directly through our extensive behavioral health network by calling the member services phone number listed on the back of their ID cards. Providers may also contact the Plan for assistance with mental health services referrals.

PCPs are responsible for coordinating referrals for members who require specialty or inpatient mental health services to the county mental health plans. 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 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.

Behavioral health therapy services are administered by the Plan. Providers may submit treatment referrals to

the Plan by calling the member services phone number on the back of the member's ID card.

REFERRAL COORDINATION

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

Behavioral health therapy 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 behavioral health therapy provider.

Dyadic Services

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

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

ELIGIBILITY REQUIREMENTS

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

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

Referrals to Dyadic services providers

Referrals can be made to the following dyadic services providers:

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

Claims billing

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

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

Transportation

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

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

NON-EMERGENCY MEDICAL TRANSPORTATION

NEMT is a covered service only when the patient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated. Additionally, NEMT is covered for patients who are ambulatory but require door-to-door assistance, 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, in accordance with the Medi-Cal Provider Manual, are:

- NEMT ambulance which includes:
  - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
  - Transfers: 1) from acute care facility to another acute care facility, immediately following an

inpatient stay at the acute level of care, 2) to a skilled nursing facility or 3) an intermediate licensed care facility.

- Litter van when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets the need for both of the following:
  - The member must be transported in a prone or supine position because the member is incapable of sitting for the period of time needed for transport.
  - Specialized safety equipment is required over and above what is normally available in passenger cars, taxicabs or other forms of public conveyance.
- Wheelchair van medical transportation services when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
  - The member is incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
  - The member must be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
  - Specialized safety equipment is required over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
- NEMT by air (requires Health Net authorization and Letter of Agreement) only under the following conditions:
  - Transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible.

NON-MEDICAL TRANSPORTATION

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

Round trip NMT is available for the following:

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

Access to Services in Primary Language

Members whose primary language has been identified as a threshold language by the DHCS receive written information in that language. The 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 a population group of eligible beneficiaries residing in the managed care plan's service area who indicate their primary language as a language other than English and meet:

- A numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower (Threshold

Standard Language); and

- The concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

The current threshold languages by county are:

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

request. Members have the right to:

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

Referrals for Specialty Care

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

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.
- Minor consent services.

- Adult sensitive care services:
  - Family planning and birth control including sterilization for adults 21 and older.
  - Pregnancy testing and counseling and other pregnancy related services.
  - HIV/AIDS prevention and testing.
  - Sexually transmitted infections prevention testing.
  - Rape and other sexual assault, treatment and collection of medical evidence.
  - Outpatient abortion services.
- Drug and alcohol abuse treatment and mental health treatment - these services are not covered by Health Net's Medi-Cal managed care plan and may be obtained through the county drug and alcohol program and the county mental health program.

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

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or embedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Other services not requiring prior authorization include:

- Certain services for American Indian members, including:
  - An American Indian member can obtain covered services from an out-of-network Indian health care provider without requiring a referral from a network primary care provider (PCP) or prior authorization.
  - MOA 638 Indian Health Services facilities or providers, whether in the Plan’s network or out-of-network, can provide referrals directly to network providers without a referral from a network PCP or prior authorization. An American Indian member may receive services from an out-of-network Indian health care provider even if there are in-network Indian health care providers available.
- DHCS-required immunizations when provided from the local health department (local health department must submit immunization records with any claim).
- Basic prenatal care with a participating network obstetrician.
- Preventive services from a participating provider.
- Services for emergency medical conditions.
- Specialist referral to a participating specialist.
- Second opinion from a participating physician or other provider.
- Urgently needs services when the member is outside of their county.
- Certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider.
- Biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (must be U.S. Food and Drug Administration (FDA)-approved).
- COVID-19 diagnostic and screening testing.
- Services that are rendered under the Children and Youth Behavioral Health Initiative fee schedule.
- Initial mental health and substance use disorder assessments.

- Adult preventive immunizations from a participating physician or other provider.
- Outpatient hospice services: Prior Authorization is not required for routine home care, continuous home care and respite care, or hospice physician services. Required documentation but be submitted to the Plan:
  - Certification of the patient's terminal illness;
  - Medi-Cal Hospice Program Election form;
  - Revocation of hospice election, documenting the patient's decision to discontinue hospice care;
  - Copy of the written initial plan of care;
  - Written prescription signed by the patient's attending physician, which includes justification for general inpatient level of care;
  - Face-to-face encounter document that verifies clinical evaluation for continued eligibility; and
  - Transfer summary when the patient changes health plan carriers

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

A referral is required for cases that are difficult to manage or when care is beyond the PCP's scope of practice. When referring a member for specialty care, the directly participating FFS PCP must follow the guidelines outlined below:

- The PCP selects a specialist from the list of participating providers in the plan's Medi-Cal provider listing. Providers may contact the Provider Relations Department for assistance if there is difficulty finding an available in-network specialist from the Medi-Cal provider listing.
- For services with an out-of-network specialist, the PCP completes and faxes the Request for Prior Authorization form to the specialist with the authorization number attached.
- For specialty visits with participating specialists, there is no need to complete a Request for Prior Authorization form or notify the 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 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 Medical Management Department, with the exception of those services for which members may self-refer without prior authorization.

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

REFERRALS TO SPECIALISTS – CAPITATED PROVIDERS

The 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 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 15 days. If the PCP has not received the specialist's report within 15 days, the PCP should contact the specialist to obtain the report. For urgent and emergency cases, the specialist should initiate a phone report to the PCP as soon as possible, and a written report should be received within 15 days.

REFERRALS TO PUBLIC PROGRAMS

Many public programs services 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 entails 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 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 ensures medical necessity of services, appropriate level of care, use of participating providers, and is intended 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 Plan.

Providers contracting directly with the Plan (FFS providers) must obtain prior authorization from the Plan or as specified on the prior authorization requirements list. The 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 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 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, helps monitor the care provided to members and provides instructions to the specialist regarding authorized services.
- The PCP and specialist retain a copy of the inpatient or outpatient prior authorization form in the member's chart.
- Fax a copy of the Request for Prior Authorization form to the Plan. You can also request authorization by phone or through the Plan's provider website.
  - This ensures that Health Net identifies case management needs and assists the member with coordination of care, when appropriate.
  - This also enables Health Net to assist in the detection of and referral to appropriate agencies for carve-out services, such as CCS.

- 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 Plan as much advance notice as possible when requesting prior authorization. For routine elective inpatient or outpatient services, the provider must fax or mail requests for prior authorization at least seven calendar days before the anticipated date of service. It is strongly recommended that services not be scheduled prior to receiving the Medical Management Department review decision. This allows sufficient time to notify the provider of the review decision prior to the services being rendered.

Submission of Requests

Fax the prior authorization form to the Plan. Use the fax number on the form to submit requests 24 hours a day, seven days a week. You can also request authorization by phone or through the Plan's provider website.

REQUIRED INFORMATION

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

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

The Plan reviews the information and issues a determination to the member/provider. If the service is authorized, the provider is notified with the authorization number.

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

Prior authorization can be requested in the following ways:

- By going to www.covermymeds.com.
- By logging into the portal and submitting the prior authorization through our Prior Authorization tool. Login from the provider portal and access the secured Prior Authorization tool.
- By sending a completed prior authorization form through fax to: 800-869-4325.

- By submitting an NCPDP P4 Transaction through Pharmacy POS system.
- By sending a completed prior authorization form through mail at:

  Medi-Cal Rx Customer Service Center
  Attn: Prior Authorization Request
  PO Box 730
  Sacramento, CA 95741-0730
  Phone: 800-977-2273

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

CHAPTER 4 – MEDICAL STANDARDS

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

Several of the requirements include mandatory physician referral for certain specialty services. The Medi-Cal Referral Service Variations matrix, included on page 56, 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 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 American Academy of Pediatrics, the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices and the American Academy of Family Physicians.
- Routine adult immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

PCP RESPONSIBILITIES

The PCP is responsible for the following:

- Providing a comprehensive initial health appointment (IHA) to all new members within 120 calendar days after the member's date of enrollment.
- Completing ongoing health assessments as indicated by the periodicity table. 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

Age	Frequency
0–20	Refer to American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care in the Medi-Cal provider
19–25	Annually
26–39	Annually
40–49	Annually
50–65	Annually
65 and older	Annually

Initial Health Appointment

All Medi-Cal members ages 18 months and older must have an IHA, which includes the member's history (history of present illness, past medical and social history, and review of organ systems) and physical examination within 120 calendar days 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.

Refer to PCP Responsibilities on page 41 for more information.

GUIDELINES

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

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

IHA DOCUMENTATION AND REPORTING

For all providers, a member eligibility report is available through 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 IHA reports on the Health Net provider website.

The plan reviews monthly claims and encounter data of comprehensive initial health appointments rendered by participating providers. These encounters are cross-checked against member enrollment data. A member eligibility report is available at the PCP's or 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 PCPs. The IHA notification instructs new members to schedule an appointment with their PCPs.

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

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

COORDINATION BY THE PLAN

The Plan sends new members a welcome packet that includes an IHA notification, provider directory, *EOC*, preventive care services, and other important plan information. Instructions are included for new members to schedule appointments with their PCPs. The Plan contacts new Medi-Cal members by phone 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. The Plan makes three outbound call attempts to newly enrolled members to remind members to schedule their IHA. 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.

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

Preventive and Screening Services for Children and Youth Under Age 21

Some preventive and screening services previously provided by the Child Health and Disability Prevention program will continue to be provided by the managed care plan. The Plan provides preventive, well-child screening services to children and youth under age 21. These services encompass the requirements of the EPSDT/Medi-Cal for Kids & Teens program, and aim to prevent childhood disability by screening children during critical times of growth and development and making referrals as necessary to improve their health.

PROVIDER CERTIFICATION REQUIREMENTS

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

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

Physicians and other providers not active in Child Health and Disability Prevention program as of June 30, 2024, must complete steps to meet eligibility requirements to become enrolled as a Medi-Cal provider and then a Children's Presumptive Eligibility provider. After enrolling in Medi-Cal and receiving

approval, providers can take the above training to participate in Children's Presumptive Eligibility as of July 1, 2024.

APPOINTMENTS AND REFERRALS

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

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

DENTAL CARE

All children with dental problems must be referred directly to a Denti-Cal dentist for care. All members ages three and older must be referred annually for preventive dental care to a dentist who accepts Denti-Cal, regardless of whether a dental problem exists. Providers or members may call Denti-Cal for a list of three Denti-Cal providers within the member's ZIP Code. The PCP is also responsible for dental assessments. Refer to the discussion of Dental Screenings on page 47 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 initial health appointment at which the condition was identified. The Medical Management Department is available to provide coordination, if indicated by the member's condition and requested by the PCP.

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

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

OBTAINING CONSENT

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

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

CERTIFICATION FOR SCHOOL ENTRY

California law requires that children entering first grade must provide their schools with a certificate documenting that they have had a preventive, well-child screening exam or a waiver of the exam signed by the parent or guardian. The exam may be done up to 18 months prior to or within 90 days after entrance into

first grade. Providers should give the parent or guardian of a child entering kindergarten or first grade a certificate documenting that the child has received the appropriate health exam. A child may be certified without a preventive, well-child screening exam if the child has received a physical exam and ongoing comprehensive medical care from that physician during the 18-month period prior to or within 90 days following entrance into the first grade. The Plan and local schools urge parents to obtain a health assessment for their child on entry into kindergarten. If a health assessment is refused by the parent or guardian, the parent or guardian must submit a waiver to the school.

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

FOLLOW-UP FOR MISSED APPOINTMENTS

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

CMS-1500 FORM CODING INSTRUCTIONS

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

For capitated physicians, the preventive and screening services for children and youth under age 21 must be reported as a Medi-Cal encounter to the 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 PREVENTIVE AND SCREENING SERVICES

Procedure description	CMS-1500 CPT/HCPCS procedure code
Physical exam, new patient, birth–11 months	99381
Physical exam, new patient, 1–4 years	99382
Physical exam, new patient, 5–11 years	99383
Physical exam, new patient, 12–17 years	99384
Physical exam, new patient, 18+ years	99203–99205
Physical exam, established, birth–11 months	99391
Physical exam, established, 1–4 years	99392
Physical exam, established, 5–11 years	99393
Physical exam, established, 12–17 years	99394
Physical exam, established, 18+ years	99203–99205
Dental assessment	Included in exam fee
Nutritional assessment	Included in exam fee
Anticipatory Guidance Health Education	Included in exam fee
Developmental assessment	Included in exam fee
Snellen or equivalent, 3–6 years	Z2702
Snellen or equivalent, 7+ years	Z2702
Audiometric	92552

Hemoglobin or hematocrit	85013–85018
Urine dipstick	81000
Complete urinalysis	81005
TB multipuncture	No longer covered
TB Mantoux – TB patch or intradermal	86580
TB Mantoux – TB tine	86585
Sickle Cell: electrophoresis handling fee	Z5218
Lead: Blood lead handling fee	Z5220
VDRL, RPR, ART handling fee	86593
G.C. culture handling fee	Z5220
Pap test handling fee	Z5220
PKU: Blood handling fee	84030
Chlamydia culture handling fee	Z5220
Pelvic exam	57410
MMR/MuR/MR immunization	90707**
Measles immunization	90705**
Rubella immunization	90706**
Hib CV immunization	90655,** 90657, 90658
Polio (IPV) immunization	90713**
Hepatitis B immunization, low dose, pediatric/adolescent, three doses	90744**
HBIG immunization	90748**
Hepatitis B immunization, high dose, adolescent, two doses	90743**
DTaP	90700**
Varicella, VFC	90716**
MMR, Non-VFC (19–20 years)	90707
Hepatitis B, Non-VFC (19–20 years)	90746
Varicella, Non-VFC	90716
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

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

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

LAB PREVENTIVE AND SCREENING SERVICES***

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

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

COORDINATION OF SERVICES WITH SCHOOL-BASED PROGRAMS

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

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

The 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 needing preventive and screening services may receive these services from the contracting school-based clinics within the required state and federal time frames. The Plan follows up and documents that preventive and screening services are provided to members. Participating school-based clinics and PCPs provide health assessments in accordance with the most recent American Academy of Pediatrics periodicity schedule for preventive health services.

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

EPSDT/Medi-Cal for Kids & Teens Services

EPSDT means the provision of medically necessary comprehensive and preventive health care services provided to members less than 21 years of age in accordance with requirements in 42 USC section 1396(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 114132(v).

Such services may also be medically necessary to correct or ameliorate defects and physical or behavioral health conditions. All EPSDT services are covered services unless they are specifically carved out from managed care, i.e. dental services, specialty mental health services, CCS.

EPSDT services, without limitation, include case management and targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services, such as pediatric day health center services, cochlear implant and transportation services. This could include services that are not usually a benefit for members ages 21 and up.

Annually by January 1, the Plan mails or shares electronically DHCS' Medi-Cal for Kids & Teens brochures to existing members under age 21. For new members, Medi-Cal for Kids & Teens materials will be mailed or shared electronically within seven calendar days of enrollment. Providers are encouraged to visit the Medi-Cal for Kids & Teens website for additional information regarding EPSDT services. Additionally, all network providers are required to complete the EPSDT-specific training no less than every two years. The Plan is required to report to DHCS on providers who have completed the training and providers who are not compliant with this training requirement.

PCPs, along with delegated PPGs or the Plan, are responsible for arranging for all medically necessary EPSDT services identified at a preventive screening or other visit identifying the need for treatment. Providers are required to ensure all EPSDT services are provided in a timely manner.

REFERRALS

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

PCPs are responsible for referring EPSDT/Medi-Cal for Kids & Teens-eligible members identified as needing behavioral health therapy services, regardless of diagnosis to the Plan for assessment and referral to a mental health provider. The Plan manages the behavioral health benefits of Medi-Cal members. Behavioral health therapy 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 behavioral health therapy provider.

CARE COORDINATION

Health Care Services staff, or the delegated PPG, work with the Public Programs specialists, service coordination liaisons and transition of care representatives to monitor the appropriate use of local government organizations, including regional centers, which provide EPSDT/Medi-Cal for Kids & Teens services.

The Medical Management staff or delegated PPG coordinates with the member's PCP to monitor that referrals are made to the proper agencies and programs. Following review and authorization by a Plan medical director or delegated PPG medical director, Health Care Services staff or the PPG coordinates the services with the PCP.

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

DOCUMENTATION

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

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

PROBLEM RESOLUTION

The Plan's service coordination liaisons, on behalf of CalViva Health, resolve disputes that arise regarding responsibility for necessary EPSDT/Medi-Cal for Kids & Teens services. Medical Management staff or the delegated PPG continues to coordinate and authorize all immediate health care needs in collaboration with the PCP until the matter is resolved.

Private Duty Nursing Services

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

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

PDN CASE MANAGEMENT/CARE COORDINATION RESPONSIBILITIES

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

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled home health agencies and enrolled individual nurse providers to seek approved PDN services on behalf of the member; and
- Working with enrolled home health agencies and enrolled individual nurse providers to jointly provide PDN services to the member.

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

REQUIREMENT FOR PDN SERVICES

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

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

All members under 21 receiving PDN services must be offered case management.

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

Providers can submit a referral to the Plan's Case Management Department by completing and submitting a case management referral form via email to CASHP.ACM.CMA@healthnet.com or by fax to 866-581-0540. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References*.

Adverse Childhood Experiences Screening

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

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

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

Childhood Blood Lead Screening

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

Immunizations

PCPs are responsible for administering immunizations to members. Local health departments 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 may also immunize CalViva Health Medi-Cal members.

The 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 local health department). 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 Plan reimburses local health departments for certain immunizations given without prior authorization. The local health department 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. Local health departments must submit a copy of the member's immunization record with the claim form. On request, the Plan assists local health departments 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 local health department 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 VFC program, a federally funded program providing immunizations to physicians serving Medi-Cal-eligible patients. It furnishes free vaccines in bulk to enrolled providers for Medi-Cal eligible children under age 19. To participate in the VFC program, complete forms at www.cdc.gov/vaccines/programs/vfc/index.html.

MEMBER OUTREACH AND EDUCATION

The 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 newsletter, immunization reminder postcards, and any other communication channels as appropriate.

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.

SERVICE COORDINATION TEAM

The Plan's Service Coordination Team works with local health departments 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 Plan's Medi-Cal contracts. The Plan is not financially responsible for covering dental services under any circumstances, including when they are provided as an EPSDT/Medi-Cal for Kids & Teens service. Participating PCPs refer members for dental services to Medi-Cal dental providers.

The 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 or certified RN anesthetist-administered anesthesia services (such as intravenous (IV) moderate sedation and deep sedation/general anesthesia for inpatient and outpatient services).
- Covered medical services related to dental services that are not provided by dentists or dental anesthetists.
- Fluoride varnish, up to three times in a 12-month period, for Medi-Cal members under age 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 preventive, well-child screening examination visit according to the periodic health examination schedules.

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

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

MANDATORY REFERRAL

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

the reason for the referral must be documented in the member's medical record.

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

Routine Eye Examinations and Eyewear

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

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

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at about age three. Children between ages 4 and 6 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.
- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus. Adults ages 21 and older are covered for bandage contacts only when medically necessary; other ophthalmological materials are not covered.

FRAMES AND LENSES

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

POLYCARBONATE LENSES

Polycarbonate lenses are covered for the following:

- Member is age 18 or younger.
- Member over age 18 who 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 the California Prison Industry Authority optical laboratories and provided with cost through the optometrist's or ophthalmologist's office participating with Centene Vision Services for those identified above.

FRAME REPLACEMENT AND REPAIR

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

REPLACEMENT LENSES[2]

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.

[2]Replacement lenses should be ordered directly through the California Prison Industry Authority 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 Plan/medical group).
- Surgical professional services normally performed by an ophthalmologist (may be covered by the Plan/medical group).
- Multifocal contact lenses.

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. Medi-Cal members have the right to receive covered nurse midwife services from any Medi-Cal freestanding birth centers and to services provided by CNMs and licensed midwives without referral or prior authorization. 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 the 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 Plan has developed assessment tools approved by DHCS that are included in the Forms and References section of the Provider Library. The multidisciplinary approach to the delivery of perinatal care in the CPSP framework is based on the recognition that providing these services from conception through 60 days following delivery improves pregnancy outcomes.

The provision of CPSP services to pregnant members is the responsibility of all California Department of Public Health-certified CPSP providers who contract with the 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 College of Obstetricians and Gynecologists recommendations and within accepted the 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.

MATERNAL MENTAL HEALTH SCREENING REQUIREMENT

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

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

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

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

COMPREHENSIVE RISK ASSESSMENT AND INDIVIDUALIZED CARE PLAN

All perinatal care providers should complete a comprehensive risk assessment and individualized care plan, even 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 California Department of Public Health are required to enter into agreements with California Department of Public Health-certified CPSP providers to ensure that all pregnant women have access to care in accordance with DHCS requirements.

REQUIRED SERVICES

Required services include:

- Client orientation.
- Obstetrical services.
- Nutrition, psychosocial and health education support services initial assessments.
- Formal reassessments at each subsequent trimester and in the postpartum period.
- Development of ICPs that include planned actions as indicated by the assessments and objectives for each of the four categories, with revision at least each subsequent trimester and postpartum.
- Case coordination.
- Vitamin and mineral supplementation.
- Referral to WIC.
- Provision of, or referral for, dental, genetic, family planning, and preventive, well-child screening care exams and services.

California Department of Public Health-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 individualized care plan, 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 individualized care plan 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 Plan assesses and tracks participating providers' ability to deliver CPSP services required by Medi-Cal. The plan monitors compliance and provision of obstetrical services according to the American College of Obstetricians and Gynecologists *Guidelines for Perinatal Care*.

BILLING

Individual participating providers who are not certified by the California Department of Public Health for CPSP are reimbursed for maternity services with a global professional fee, which includes all professional services normally provided for routine perinatal care. CPSP providers should bill each service separately, using the DHCS-designated Z codes.

Social Determinants of Health

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

HOW TO SUBMIT SOCIAL DETERMINANTS OF HEALTH DATA

Refer to the 18 DHCS priority social determinants of health codes below when documenting social determinants of health as they relate to your patient. Submit these on claims or encounters. The codes are based on the ICD-10-CM.

DHCS priority social determinants of health codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z59.0	Homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.7	Insufficient social insurance and welfare support

Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance and death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Special Supplemental Nutrition Program for WIC

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

WIC PROGRAM SERVICES

WIC participants receive a packet of food vouchers each month that they can redeem at a local retail market of their choice. They can be redeemed for fresh produce at select farmer's markets, as well as 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 PPG or the Plan.

IDENTIFYING ELIGIBLE BENEFICIARIES

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

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

Medi-Cal members must also:

- Receive regular medical check-ups.
- Meet income guidelines.
- Reside in a local agency's service area.

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 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 Plan’s community liaisons negotiate a memorandum of understanding with local WIC agencies to facilitate coordination and communication between the Plan and the agency. The Plan’s community liaisons also works with WIC agency liaisons to handle conflicts that might arise between the WIC agency and the Plan or a participating provider.

CHAPTER 5 – SENSITIVE AND 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 24. A summary, the Medi-Cal Referral Variations Matrix, is included on page 56.

Sensitive Services

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

Sensitive services are:

- Family planning and birth control. For adults ages 21 and older, these services include sterilization.
- Pregnancy testing and counseling and other pregnancy-related services.
- HIV/AIDS prevention and testing.
- Sexually transmitted infections prevention, testing, and treatment
- Sexual assault care
- Outpatient abortion services
- Minor consent services (refer to the Minor Consent Services section for details)

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 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 Plan or the PPG is responsible for payment to out-of-network providers for these services.

Minor's Consent for Services

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

	Minor may consent if age 12 and	Minor may consent if under age 12
Family planning (prevention and treatment of pregnancy, except sterilization)	Yes	Yes
Abortion* (termination of pregnancy)	Yes	Yes
Rape and other sexual assault	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	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.
  - Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent or guardian consent is necessary for maintenance narcotic replacement therapy.
- Mental health care – Refer to the Public Programs topic for additional information. Members ages 12 or older can consent to mental health treatment or counseling without needing to meet specific conditions. Additionally, mental health professionals can now consult with minors before involving their parents or guardians if they believe it's inappropriate to do so.

MEDI-CAL REFERRAL SERVICE VARIATIONS

	Mandatory referral[3]	Self referral[4]	Out-of-network provider[5]
Preventive and screening for newborns6	X		No
CPSP services	X		No
Dental – annually for children over age 3	X	X	N/A
Elective pregnancy termination		X	Yes
Family planning (including pregnancy testing)		X	Yes
HIV testing and counseling	X (w/pregnancy)	X	Yes
Immunizations		X	Local health department only
OB care		X	No
STIs		X	Yes
WIC	X		N/A

[3]Program-mandated services to which a PCP must refer the member.

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

[5]Services members may obtain from a non-participating provider as indicated.

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

Family Planning Services

Medi-Cal members have the right to access family planning services without referral or prior authorization from any qualified Medi-Cal enrolled participating or 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, physician assistants, federally qualified health centers (FQHCs), Indian Health Clinics (IHCs), Rural Health Centers (RHCs), and county family planning providers. Providers may not restrict a member's access to family planning services. Providers who do not comply are subject to administrative review or disciplinary action.

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 guidelines).
- Diagnosis and treatment of STIs.
- Screening, testing and counseling of individuals at risk for HIV infection.
- Most methods of sterilization (the member must be at least age 21 at the time consent is obtained), including:
  - tubal ligation
  - vasectomy
- The same methods of birth control as covered by DHCS for the Medi-Cal FFS program, devices and supplies

(including Depo-Provera® and LunelleTM). Members may receive up to a 12-month supply dispensed at one time for FDA-approved, self-administered hormonal contraceptives, such as 13 vaginal rings, 52 patches and 18 cycles of oral contraceptives.

- Oral contraceptives are covered when dispensed from an onsite clinic and billed by any qualified provider. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a Medi-Cal enrollee as specified in Title 22, California Code of Regulations, Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, nurse practitioner, and pharmacist are authorized to dispense medications. When furnished by a pharmacist self-administered hormonal contraceptives must be dispensed in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Pursuant to the California Business and Professions Code (B&P Code), Section 2725.2, if contraceptives are dispensed by an RN, the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with evaluation and management (E&M) procedure codes 99201, 99211 or 99212 with modifier TD (used for behavioral health RN) as directed in the DHCS Medi-Cal Provider Manual.
- Office-administered follow-up treatment of complications associated with contraceptive methods issued by the family planning provider (limited to two outpatient visits without prior authorization, when provided by a 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 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 Plan's community liaisons for resolution. During any problem periods, the Plan care manager and the PCP or specialty provider continues to coordinate the member's care.

HIV Testing and Counseling

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

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 guidelines for pre- and post-testing counseling.

Members may also obtain confidential or anonymous HIV testing and counseling services from the local health department, community-based organization testing site or non-participating family planning provider. The member's PCP must perform follow-up services. Members who are age 12 and

older may get HIV/AIDs preventive, testing and treatment services without parent's or guardian's permission.

MANDATORY OFFERING

PCPs are required to counsel and offer HIV testing to pregnant Medi-Cal members. The Plan recommends the use of the California Perinatal HIV Testing Project guidelines available on the California Department of Public Health website at http://www.cdph.ca.gov.

RELEASE OF CONFIDENTIAL PATIENT MEDICAL INFORMATION

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

If a copy of the member's medical record is requested, the custodian of records must review the record and remove the confidential envelope containing the consent form or the HIV test results, along with any other portion of the record that contains documentation of the HIV test being ordered or the HIV test results (for example, history, physical, consultations and progress notes). If the HIV test or HIV test results are mentioned anywhere in the medical record, the information is protected. If necessary, the custodian must explain that the protected portion of the record requires special written authorization from the member. The custodian of records must not identify in any way that the record is confidential because of the HIV or AIDS test. It must state that it is a protected record under state law that requires special authorization from the member. After removing all confidential material, the record may be released to the requestor.

Pregnancy Services and Pregnancy Termination

Pregnancy services are covered in chapter 4 of this guide beginning on page 55.

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 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 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 local health departments 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 local health departments and family planning providers are limited to the following:

- one office visit per disease episode for the purposes of:
  - (1) diagnosis and treatment of vaginal discharge and urethral discharge,
  - (2) those STIs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma

virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale; and

- (3) evaluation and treatment of pelvic inflammatory disease.

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

For community providers other than local health department 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 local health department clinics, participating specialists, or, on request of the member, out-of-network providers.

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

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

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

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

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

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

NON-PARTICIPATING PROVIDERS

The 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 phone 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 Medical Management Department. The Medical Management 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 Health Education System sends STI health education information to providers on request.

REIMBURSEMENT

Participating Providers

Participating providers must bill in accordance with their *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*.

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

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

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

CHAPTER 6 – PUBLIC HEALTH CARVE-OUT SERVICES

Public health programs provide a wide variety of services to Medi-Cal members at the county, state and federal levels. Physicians, public health programs and the 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 Plan. Members using these services continue to be enrolled with the 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 68, lists the public health programs available to Medi-Cal members and indicates the type of program; status of member enrollment when these services are used; and payer, referral and authorization sources (waiver programs are covered in Chapter 7).

Referral Notification

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

- Member name.
- Member ID number.
- Provider name.
- Date and type of referral.
- For CCS, include diagnosis.

Problem Resolution

Unless otherwise noted, disputes or problems that arise between the public health programs described in this chapter and the Plan or the PCP are handled by the Plan's community liaisons. 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 the Plan contract	Waiver[7]	Carve out[8]	Disenrolled	Enrolled	Referral source	Authorizing source	Payer source
Medi-Cal waiver	X	X		X (patient choice)		PCP, Specialist	Local Medi-Cal Waiver	Local Medi-Cal Waiver
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 and Community-Based waiver – Department of Developmental Services (DDS)	X	X			X	PCP	Regional Center	Regional Center
Home and Community-Based waiver – IHO (IHMC, SNF, Model)	X	X		X		PCP	IHO Sacramento	IHO Sacramento
Home and Community-Based waiver – DOA (MSSP)	X		X		X	PCP, Specialist, Self	Dept. of Aging Local Contractor	Dept. of Aging Local Contractor
LEA	X		X		X	Self, PCP	LEA	LEA
Specialty mental health only	X		X		X	PCP, Self	County Mental	County Mental
Organ transplant – child (CCS)	X		X		X	PCP, Specialist	CCS	CCS
Regional center coordination (Early Start)	X		X		X	PCP, Specialist	DDS	DDS
Refugee health	X		X	N/A	N/A	PCP, Other	Local health department	Local health department

[7]Programs in which payer source is other than the Plan and the member is usually disenrolled (exceptions: HCBS waivers under DDS and MSSP).
[8]Programs in which the payer is other than the Plan and the member is not disenrolled.

Alcohol and Drug Treatment Services

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

The 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. Additionally, participating PCPs must maintain documentation of Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services. Member medical records must include the following:

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

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

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

REFERRAL DOCUMENTATION

Participating providers are responsible for performing all preliminary testing and procedures necessary to develop a diagnosis. Referrals to D/MC or FFS Medi-Cal 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 Medi-Cal or D/MC services (authorization of the referral) rests solely with the county alcohol and drug program.

MEDICATION ASSISTED TREATMENT

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

CONTINUITY OF CARE

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

On receipt of a specific written request from the member, the PCP must transfer requested summaries of the member's records to the substance abuse 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 Plan's confidentiality standards.

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

California Children's Services (CCS)

The 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 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 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 team performs examinations and prescribes PT, OT, DME, and any other necessary medical interventions required to treat the child's CCS-eligible diagnosis. Medical therapy units 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 program provides outpatient services to infants who meet the CCS medical eligibility criteria for a CCS-approved neonatal intensive care unit (NICU), or had a CCS-eligible medical condition during their stay in a CCS-approved NICU, even if they were never CCS clients during their NICU stay. This also includes newborns who are at risk of developing a CCS-eligible medical condition. These services include comprehensive history and physical examination, including neurological and developmental assessment, ophthalmological and audiological evaluations, and family psychosocial and home assessments, including coordination of High-Risk Infant Follow-Up services during the first three years of life.

Orthodontic Screening Program

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

Family income is not a factor for children who:

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

CCS-ELIGIBLE CONDITIONS

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

- Infectious diseases (HIV when confirmed by laboratory tests, osteomyelitis).
- Neoplasms (cancers, tumors).
- Endocrine, nutritional and metabolic diseases and immune disorders (thyroid problems, diabetes, PKU).
- Diseases of blood and blood-forming organs (hemophilia, sickle cell problems).

- Mental disorders and intellectual disability (conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS-eligible condition).
- Diseases of the nervous system (cerebral palsy, multiple sclerosis).
- Diseases of the eye (glaucoma, cataracts).
- Diseases of the ear and mastoid process (hearing loss, mastoiditis, cholesteatoma).
- Diseases of the circulatory system (tetralogy of fallot, pulmonary atresia, coactation of aorta).
- Diseases of the respiratory system (cystic fibrosis, respiratory failure).
- Diseases of the digestive system (diseases of the liver, chronic intestinal failure).
- Diseases of the genitourinary system (chronic nephrosis, acute kidney failure, chronic renal disease).
- Diseases of the skin and subcutaneous tissues (pemphigus, epidermolysis bullosa).
- Diseases of the musculoskeletal system and connective tissue (rheumatoid arthritis, lupus erythematosus).
- Congenital anomalies (spina bifida, hydrocephalus, cleft palate and cleft lip).
- Accidents, poisonings, violence, and immunization reactions (ORIF, fractures involving joints/growth plates).
- Pediatric intensive care.

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

REFERRAL TO CCS

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

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

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

Referrals to CCS must include:

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

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

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

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

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

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

CCS APPLICATION AND SERVICE AGREEMENT FORM

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

CCS and the 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.

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 SAR New Referral CCS/GHPP Client SAR (ca.gov), Established CCS/GHPP Client SAR (ca.gov) must be obtained by the hospital and provider for each hospitalization.

TRACKING AND COORDINATION OF CARE

Participating providers are required to develop and implement a procedure for tracking CCS program referrals. The Plan is available to work with participating providers and care managers to facilitate referrals to CCS and continuity of care as needed.

PUBLIC PROGRAMS CCS TEAM COORDINATION

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

County Mental Health Plan

Services available under the Medi-Cal specialty mental health program are excluded from the 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. Each county is required by law to provide access to specialty mental health services for Medi-Cal members, which are overseen by the California Department of Mental Health.

SPECIALTY MENTAL HEALTH SERVICES

Specialty mental health services covered by the county mental health plans 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 county mental health plan 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 county mental health plan.

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 the Plan 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 the Plan at 844-966-0298 for assistance.
- For members with a severe level of impairment, refer to the county mental health plan for specialty mental health services.

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

THE PLAN RESPONSIBILITIES

The 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 EPSDT/Medi-Cal for Kids & Teens services for members under age 21).
- Provide medically necessary 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 local health departments 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 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 local health department rather than the Plan.

DOT REFERRALS TO LOCAL HEALTH DEPARTMENTS

When a PCP identifies a member with TB who is at risk of nonadherence with the treatment regimen, the PCP must fax a copy of the DOT referral form to the local health department TB control officer. A copy of the referral form must also be faxed to the Plan Service Coordination Liaisons and the PPG case manager.

The local health department 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 local health department TB control officer and provide follow-up care to all members receiving DOT services. PCPs need to inform the local health department TB Control Program of any changes in the member's response to the treatment or medication therapy.

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

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

TRACKING AND COORDINATION OF CARE

The 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, the Medi-Cal Medical Management Department is available to provide assistance with coordinating the member's care.

Early Start Program

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

PCP RESPONSIBILITIES

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

- Initial comprehensive physical evaluation for congenital abnormalities and/or treatable medical conditions.
- Developmental screening using EPSDT/Medi-Cal for Kids & Teens and/or American Academy of Pediatrics standards. PCP also arranges for the provision of medically necessary behavioral health therapy services even without a diagnosis of Autism Spectrum Disorder. The Plan provides the behavioral health therapy services.
- 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.
  - Toxic exposure.
  - Genetic/congenital disorder.
  - Infection or disease of the central nervous system.
  - Brain malformation or brain injury.
  - Visual or hearing impairments.
  - Family history of developmental delay.
- Are at high risk of having a substantial developmental disability due to a combination of biomedical risk factors:
  - Prematurity less than 32 weeks and/or birth weight <1500 grams.
  - Ventilator greater than 48 hours.
  - Small for gestational age.
  - Asphyxia neonatorum associated with a five minute – Apgar of 0 to 5.
  - Multiple congenital anomalies.
  - Failure to thrive.
  - Persistent hypertonia/hypotonia.

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

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

REFERRALS TO EARLY START PROGRAMS

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

REFERRAL COORDINATION WITH CCS

In situations where the child is eligible for both CCS and DDS Early Start programs, the primary referral is to CCS if diagnosis or treatment for CCS-eligible conditions is the primary concern. The PCP must notify CCS and the regional center simultaneously if both medical and Early Start program services are indicated.

COORDINATION OF CARE

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

Once the referral has been made, the PCP:

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

PUBLIC PROGRAMS COORDINATION

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

The Plan's Public Programs specialists, service coordination liaisons and transition of care representatives are available to participate in the community Local Interagency Coordination Areas (LICA). The Plan's Public Programs specialists work with regional centers to enhance collaboration and coordination.

Local Education Agency Services

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

LEA ASSESSMENT SERVICES

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

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

PCPs are encouraged to inform members of these services; however, members may obtain services without

a referral from their PCP. PCPs should, whenever possible, coordinate needed medical services with LEA providers to promote continuity of care and ensure proper and timely follow-up. LEA medical services may include:

- Physical and occupational therapy.
- Speech pathology and audiology.
- Psychology and counseling.
- Nursing services.
- School health aide services.
- Medical transportation.
- Behavioral health screenings and treatment.
- Behavioral health wellness programs and services.

PCPs may be asked to support LEAs with the following:

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

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

Long-Term Care

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

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

Turnaround times are as follows:

For LTC authorizations:

- 72-hour turnaround time (TAT) for members transitioning from an acute care hospital to a skilled nursing facility (SNF).
- 7 calendar day TAT for LTC concurrent review requests. Placement requirements are five business days for Los Angeles and Sacramento counties, seven business days for San Joaquin and Stanislaus counties, and 14 business days for all other counties.

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

SUBACUTE CARE FACILITIES

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

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

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

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

IDENTIFICATION

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

- Physician identification – The member's PCP or specialist makes a diagnosis that requires services in an LTC facility. The physician then contacts the Plan's UM Department or PPG, if UM responsibilities have been delegated to the PPG, to request prior authorization for admission.
- Concurrent review – The 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 member for LTC services are reviewing retroactive claims for LTC services or through social workers, discharge planners and other health care providers involved in the member's care.

COORDINATION OF CARE

The PCP continues to provide care during the transition to LTC and coordinates with the LTC attending physician to ensure the member's care continues without delay. 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 (MOT) for Members Ages 21 and Over

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

The Plan covers the cost of medically necessary, non-experimental and non-investigative organ and stem cell transplants at a Medi-Cal approved Center of Excellence (COE) transplant program which operates within a hospital setting. Transplant programs that perform corneal, autologous islet cell, or kidney transplants are not required to be a Medi-Cal approved COE as they are not considered MOT.

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

REFERRAL PROCESS

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

The Center must submit a prior authorization request for the evaluation to the Centene Centralized Transplant Unit (CTU) through the provider portal, or via fax directly to the CTU at 833-769-1142. All transplant evaluation prior authorization requests must be submitted by the designated transplant Center and include the complete medical documentation required to support a determination of medical necessity.

If the submitted information is incomplete or insufficient, the CTU will contact the facility to request the additional documentation needed to complete the review. If approved, the Center is provided an authorization number for the evaluation.

Once a member has completed an evaluation and is approved by the Center for transplant, the Center must submit a prior authorization request for listing to the CTU through the provider portal, or via fax directly to the CTU at 833-769-1142. All transplant listing prior authorization requests must be submitted by the designated transplant Center and include the complete medical documentation required to support a determination of medical necessity. If the submitted information is incomplete or insufficient, the CTU will contact the facility to request the additional documentation needed to complete the review Once the CTU completes the review, the Center will be notified of the determination. If approved, the Center is provided an authorization number for the evaluation.

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

Transplants for Members Under Age 21

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

REFERRAL TO CCS

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

Refugee Health Programs

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

MEMBER IDENTIFICATION

Members requiring refugee health services may be identified through:

- Community-based organizations.
- Initial health appointments.
- Inpatient admissions (concurrent review).
- PCPs and specialists.
- Care management services.
- Emergency room and urgent care use information.
- Public programs coordination, Medi-Cal Member Services, Health Education or Provider Relations departments, or Medi-Cal Provider Services Department.
- Authorization data.
- Claims and encounter data.

- School-based clinics.
- Out-of-network providers.

Due to the importance of timely identification of newly arrived refugees, especially for the reporting of communicable diseases, the 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 local health department within the timetable in Title 17, CCR Section 2500, *Reporting to the Local Health Authority*. Information reportable to the local health department includes:

- Patient demographics (name, age, address, home phone number, date of birth, gender, ethnicity, and marital status).
- Locating information (employer, work address and phone number).
- Disease information (diseases diagnosed, date of onset, symptoms, laboratory results, and medications prescribed).
- Documentation regarding preventive care health education provided at the time of a routine exam for all members with high-risk behaviors for STI or TB infection.

PCPs may refer members to local health department 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

The Plan's community liaisons maintain regular contact with the Refugee Health Medical Assistance Program. The Medical Management staff is available to provide assistance with coordination of care if indicated by the member's condition or requested by the PCP or the Plan's community liaisons.

OUT-OF-NETWORK COORDINATION

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

Regional Center Coordination

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

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

The PCP also arranges for the provision of medically necessary behavioral health therapy services even without a diagnosis of Autism Spectrum Disorder. The Plan provides the behavioral health therapy services.

ELIGIBILITY DETERMINATION

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

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

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

REFERRAL PROCESS

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

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

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

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

REFERRAL COORDINATION WITH CCS

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

PCP RESPONSIBILITIES

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

- Referral to specialists and subspecialists for treatment of complex medical problems.
- Referral to mental health care providers for diagnosis and treatment of mental health disorders outside the

scope of the PCP's practice.

- Identify members under age 21, with potential or confirmed ASD, and refer to contracted autism service provider for evaluation or treatment.
- Referral to state-approved services when in need of prenatal genetic diagnostic services.
- Documentation of all activities related to the referral in the member's medical record.

REGIONAL CENTER RESPONSIBILITIES

Regional centers are not responsible for 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.

PUBLIC PROGRAMS COORDINATION

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

CHAPTER 7 – PUBLIC HEALTH WAIVER PROGRAMS

Public health programs provide a wide variety of services to Medi-Cal members at the county, state and federal level. Physicians, public health programs and the 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 Plan.

Members receiving services through one of the waiver programs usually disenroll from the 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 68, 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 Plan or the primary care physician (PCP) are handled by the Plan's community liaisons. During any such period, the Medical Management staff and the PCP or specialty provider continue to coordinate the care of the member.

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

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

The goals of the MCWP are to:

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

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

ELIGIBILITY

Members must meet the California Department of Public Health's Medi-Cal Waiver program eligibility requirements to participate through the Plan. Managed care members are not required to disenroll from the Plan in order to enroll in the Medi-Cal FFS Medi-Cal Waiver program. To qualify, members with AIDS or symptomatic HIV disease must meet the California Department of Public Health'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 California Department of Public Health 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 California Department of Public Health 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 Medi-Cal Waiver program prior to use of Medi-Cal Waiver program services.
- Must not be simultaneously enrolled in Medi-Cal hospice, but may be simultaneously enrolled in Medicare hospice.
- Must not be simultaneously enrolled in the AIDS Case Management program.
- Must not simultaneously receive case management services or use State Targeted Case Management Services program funds to supplement the Medi-Cal Waiver program.
- Must have an attending PCP willing to accept full professional responsibility for the recipient's medical care.

MEDI-CAL WAIVER PROGRAM CARE MANAGEMENT

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

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

California Department of Public Health's Medi-Cal Waiver program care management team locates, coordinates and monitors services for enrollees. This includes developing a written service plan and assessing the service requirements and medical condition of the enrollee. Medi-Cal Waiver program care management is performed by a team that includes a program nurse care manager, social worker or foster child case-worker (if needed), attending physician, and member.

The California Department of Public Health's Medi-Cal Waiver program care manager may authorize Medi-Cal FFS in-home skilled nursing care, attendant care, homemaker care, psychosocial counseling, equipment and minor physical adaptations to the home, Medi-Cal supplement for infants and children in foster care, non-emergency medical transportation, nutrition counseling, nutritional supplements, and home-delivered meals.

REFERRAL AND COORDINATION OF CARE

The PCP, medical management staff or both inform eligible members about the Medi-Cal Waiver program. If the member believes she or he is eligible and requests program referral, the type of supportive care needed is identified and the Medical Management or Public Programs staff initiates a referral.

The California Department of Public Health Office of AIDS assesses the member based on the California Department of Public Health's Medi-Cal Waiver program criteria for enrollment eligibility.

With the member's consent, the PCP or Medical Management staff forwards any available relevant medical documentation to the program, including the member's medical history, lab results and an outline of the therapeutic regimen. For members who elect to remain enrolled in both the plan and Medi-Cal Waiver program, the Medical Management staff concurrently institutes a care management plan and coordinates with the member's PCP.

The member's PCP and Medical Management staff are responsible for developing a primary care management plan that covers all medically necessary treatment and meets the health care needs of the member diagnosed with AIDS. They are responsible for coordinating and authorizing pharmacy services under the medical benefit, inpatient services, outpatient services, infusion services, laboratory, specialty referrals, durable medical equipment (DME), preventive care services, and respiratory care services.

If the member elects to disenroll from the plan, the medical management staff contacts the Medi-Cal Member Services Department to initiate the disenrollment. The Medical Management staff is responsible for authorization of services and coordination of the member's medical care until the member enters the Medi-Cal Waiver program.

Home and Community-Based Services Waiver Administered by the Department of Developmental Services

The primary goal of the Department of Developmental Services (DDS)-administered Home and Community-Based Services (HCBS) Waiver program is to ensure consumer choice of waiver services and consumer satisfaction, and to provide safeguards necessary to ensure the health and safety of each consumer in the program. The DDS-administered HCBS Waiver program includes an array of services designed to support those with development disabilities in either a home or community-based setting as an alternative to care in a care facility for the developmentally disabled. The HCBS Waiver program is available to developmentally disabled persons regardless of their age. A developmental disability is defined as a disability that originates before an individual attains the age of 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual.

As of January 1, 2024, the Plan provides all medically necessary covered services for members residing in or obtaining care in an ICF/DD Home, including home services, professional services, ancillary services, and transportation services. The Plan ensures members in need of ICF/DD home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. The Plan must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services.

DDS-ADMINISTERED HCBS WAIVER PROGRAMS

The DDS has administrative responsibility for the state's five developmental centers and 21 regional centers. DDS oversees the regional centers and administers the HCBS Waiver program. The DDS-administered HCBS waiver program provides specialized services in the member's family home.

The regional center service coordinator is responsible for determining the DDS HCBS Waiver setting that

is best for the eligible developmentally disabled member. Although the regional centers provide overall care management, they are not responsible for direct medical services. During the member's participation in the DDS-administered HCBS Waiver program, a participating PCP continues to provide all primary care and other medically necessary services.

ELIGIBILITY

To be eligible for Regional Center services, an individual must have a developmental disability that originates before 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. Developmental disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (Assembly Bill 8461977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes, disabling conditions found to be closely related to mental retardation intellectual disability, but does not include other handicapping conditions that are solely physical in nature.

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 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 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 Plan. The PCP continues to provide all medically necessary covered services and coordinates the member's care. The 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 as needed.

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.

HCBS WAIVER PROGRAMS

Home and Community-Based Services (HCBS) Waivers allow states that participate in Medi-Cal in California to develop creative alternatives for individuals who would otherwise require care in a nursing facility or hospital. Medi-Cal has an agreement with the federal government, which allows for waiver services to be offered in either a home or community setting. The services offered under the waiver must cost no more than the alternative institutional level of care.

ELIGIBILITY

To qualify for potential enrollment into the HCBS waiver, members must meet the following criteria:

1. Must have full-scope Medi-Cal eligibility
2. Physically disabled (no age limit)
3. This waiver will serve Medi-Cal beneficiaries, who in the absence of this waiver, and as a matter of medical necessity, would require care in an inpatient nursing facility (NF) providing the following types of care:
    - Nursing Facility (NF) B level of care
    - NF A level of care
    - NF Level B pediatric Services
    - NF subacute services
    - NF pediatric subacute services

The Plan Population Health Department monitors and reviews all inpatient stays for proper use and to identify members who may benefit from HCBS Waiver programs.

REFERRALS TO HCBS

The PCP needs to inform the member, guardian or authorized representative about the availability of in-home care alternatives. On consent of the member, guardian or authorized representative, the Population Health Department coordinates with the inpatient facility discharge planner and care manager to refer the member to a licensed and Medi-Cal-certified home health care agency for evaluation. The home health agency's care managers evaluate the member's health care needs and whether they can be met in the member's home.

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) 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).
- MSSP is provided by licensed MSSP sites. MSSP is not a managed care benefit.

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 for MSSP may be identified through a variety of sources, including, the member’s PCP or specialist, community-based organizations, inpatient admissions (concurrent review), or claims and encounter data. Members may also apply for MSSP directly by calling the Plan Public Programs Department.

With the member's consent, the Plan provides case management information required by the MSSP. A team of health and social service professionals determine the member's eligibility for MSSP participation. The team's assessment determines the member's medical diagnosis, physical disabilities, functional abilities, psychological status, and social and physical environment. The Plan case managers continue to provide needed care coordination with the member's PCP and other community agencies pending MSSP waitlist activity.

The PCP and other providers continue to render medically necessary care while the member participates in the MSSP.

CHAPTER 8 – HEALTH CARE MANAGEMENT

Comprehensive care management is necessary when a member has multiple problems or diagnoses resulting in a high-risk catastrophic or fragile medical condition. 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, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

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

CARE MANAGEMENT

The program is based upon a model that uses a multi-disciplinary care management team, recognizing that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

There are two different levels of case management:

- Basic population health management.
- Complex care management.

Basic Population Health Management

1. **Care Coordination** – Appropriate for members with primarily social determinants of health needs, such as housing, financial, etc., with the need for referrals to community resources for assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may aid if minor health concerns arise. Services at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure follow through. In addition, this level of care management is used for continuity of care transitions and supplemental support for members managed by the county.
2. **Care Management** – Appropriate for members needing a higher level of service, with clinical needs. Members in care management may have a complex condition or multiple co-morbidities that are generally well-managed. Members in care management typically have adequate family or other caregiver support and need moderate to minimal assistance from a care manager. Services at this level include those provided at the level of care coordination along with identification of member agreed-upon goals, identification of actions needed to meet the goals, and necessary support to meet those goals.

Complex Care Management (CCM)

CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner.

CCM is for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have

been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life.

CCM is provided by the Plan for members who need additional support to avoid adverse outcomes, and/or those who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care.

Services at this level include all coordination and care management services described above, along with more frequent member contact to assess continued appropriateness and adherence with their treatment plan, and progress toward meeting goals.

Care managers monitor members' key indicators of disease progress, e.g., hemoglobin A1c levels and medication adherence. Care managers also evaluate members for referral to enhanced care management (ECM) services as appropriate.

Complex Case Management Program

The Complex Case Management program identifies members as being at high risk for hospitalizations or poor outcomes and who have barriers to their health care. The program uses an evidence-based, approach, which is member-focused and goal-directed, in developing, implementing and monitoring the care plan. Trained nurse care managers, in collaboration with a multidisciplinary team, provide coordination, education and support to the member in achieving optimal health, enhancing quality of life and accessing appropriate services.

This program supports the member, family and caregivers by coordinating care and facilitating communication between health care providers. Once a member is selected to participate in the program, a case manager contacts the member's provider to coordinate care.

Outcomes for this program include:

- Completion of a comprehensive health assessment that identifies medical needs (including primary and specialty care), medication management, DME needs, and other psychological and social needs.
- Collaboration between the case manager, member (family and caregiver), multidisciplinary team, PCP, and other clinical providers to develop an individual written plan of care that is communicated to the provider and medical home.
- Coordination of care, including provision of emotional and social support, for acute and chronic illness.
- Improved member knowledge of their illnesses, self-management skills, health care options, and available services.
- Avoidance of unnecessary emergency visits and hospitalizations, seamless transitions between levels of care and the appropriate use of resources.

On an ongoing basis, the Plan evaluates the efficacy of this program by reviewing and comparing specific member outcomes and utilization before and after case management intervention.

REFERRAL TO CARE MANAGEMENT

The referral is made to the Case Management Department. Indicators that a member may be appropriate for care management may be based on diagnosis, potential treatment, frequent hospitalizations, extended hospitalizations, location of care, and patterns of care. To refer a member for case management, use the Care Management Referral Form located in the Forms and References section of the Provider Library. Members with urgent behavioral health needs can be referred directly to a participating behavioral health provider in the Plan's network, or to the local county mental health plan for more severe symptoms and risk factors.

PALLIATIVE CARE SERVICES

Eligible members at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure, COPD or liver disease. Life expectancy is 12 months or less, health status continues to worsen and the emergency department or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

REFERRALS

Palliative care services provide extra support to current benefits. The plan's palliative team and approved palliative care providers work with other health care team members and services to coordinate palliative services with ongoing medical services.

Providers can refer an eligible Medi-Cal member to palliative care. Complete and send an Outpatient California Medi-Cal Prior Authorization Form and related medical records, by email or fax to the Plan. The form is located in the Forms and References section of the Provider Library.

PCP RESPONSIBILITIES

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

CARE MANAGEMENT FOR CARVE-OUT SERVICES

Some services, such as major organ transplant for members under age 21, have been carved out of the Plan and are not covered by the Plan under its Medi-Cal managed care contract with the DHCS. Transplant cases for members under age 21 are managed by the state. County care management programs include CCS, waiver and regional center programs. Refer to the detailed description of the individual program as discussed in chapter 6, Public Health Carve-out Services and chapter 7, Public Waiver Programs of this guide. For a complete list of carve-out services refer to Member Handbook.

REFERRALS TO STATE OR COUNTY CARE MANAGEMENT PROGRAMS

When a member is identified as eligible for a county or state-supported health care program, a 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 care delivery and services for a member, either within services covered by member's Medi-Cal plan or for services that are carved out to other delivery systems, including but not limited to Medi-Cal RX, waiver programs, the county mental health plan, etc. The goal is to ensure 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.
- Referrals for 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 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 develops protocols to maintain care coordination. A log system for tracking prior authorizations, referrals to specialists, follow-up for 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 Plan all Medi-Cal members who have been referred to the Medical Management Department, excluding those referred for sensitive services, such as HIV testing and counseling, family planning, and alcohol and drug abuse treatment. Notification to the Medical Management Department may be made via mail or fax and must include the following information:

- Member name.
- Member 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 – phone call to member (or a written letter must be sent if the member does not have a phone).
- Second attempt – if the member does not respond to the first attempt, a second phone call must be made to the member (or a written letter must be sent if the member does not have a phone).
- Third attempt – if the member does not respond to the second attempt, a written letter must be sent.

Documentation must be noted in the member's medical record regarding any missed or canceled appointments, reschedule dates and attempts to contact.

MISSED PROCEDURE OR LABORATORY TEST

Appointments for procedures or tests may be missed or canceled. The provider must contact the member by phone or letter to reschedule. Documentation must be noted in the medical record regarding any missed or canceled procedures or tests, reschedule dates, and any attempts to contact the member.

CHANGE IN MEMBER STATUS

The PCP must develop office procedures to remain informed about changes in the member's status (for example, the member has changed PCP, been hospitalized or died) with notation in the medical record.

The PCP may obtain this information from member enrollment data. Further, the PCP should receive information regarding hospital admissions within 24 hours or one business day when an admission occurs on a weekend from the facility, the member, PPG, or the 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 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 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 seven calendar days of receipt of the request.

The requesting provider must be informed of these decisions via phone or fax within 24 hours after the decision is made. Follow-up written notification of approvals, denials or modifications must be made

within two business days of the decision.

Expedited Prior Authorization for Urgent Care

Expedited prior authorization occurs when the requesting provider determines that the standard decision-making time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. These decisions must be determined within 72 hours of receipt of the request.

The requesting provider must be informed of these decisions via phone or fax within 24 hours after the decision is made. Follow-up written notification of approvals, denials or modifications must be made within two business days of the decision.

Hospice Inpatient Care

Original Medi-Cal (FFS program) does not permit prior authorization of hospice services except for inpatient admissions; as outlined in state law (22 CCR 31549.) Therefore, the Plan must adhere to the same utilization review standards, as required by federal law (Title 42 CFR section 7438.210)(a)).

Hospices must notify the Plan of general inpatient care placements that occur after normal business hours on the next business day.

Submit the following documents to the Plan for prior authorization of general inpatient care:

- Certification of the patient's terminal illness;
- Medi-Cal Hospice Program Election form;
- Revocation of hospice election, documenting the patient's decision to discontinue hospice care;
- Copy of the written initial plan of care;
- Written prescription signed by the patient's attending physician, which includes justification for general inpatient level of care;
- Face-to-face encounter document that verifies clinical evaluation for continued eligibility; and
- Transfer summary when the patient changes health plan carriers.

Per All Plan Letter (APL) 25-008 issued by the DHCS on May 5, 2025, coverage is now limited to in-network hospice providers, unless medically necessary services are unavailable in-network.

Concurrent Review

Concurrent review decisions for treatment regimens already in place (such as inpatient or ongoing/ambulatory services) must be determined within seven calendar 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 approvals, 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 and member must be notified of these decisions within 30 calendar days of receipt of the request.

HOSPITAL AND INPATIENT FACILITY DISCHARGE PLANNING AND NOTIFICATION

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for CalViva Health members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization. For any concurrent authorization that is denied, care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a SNF, ICF, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The Transitional Care Services at 866-801-6294 is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Hospitals and inpatient facilities must have policies and procedures in place when transitioning members from hospitals or inpatient facilities to their homes and other community-based settings to support effective care transitions. Hospitals and inpatient facilities must notify and communicate with the member's PCP and ECM provider of discharge from hospitals or inpatient facilities. Information regarding each medication dispensed must be given to the member upon discharge.

CLINICAL CRITERIA FOR UTILIZATION MANAGEMENT DECISIONS

To determine medical appropriateness, the Plan UM 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.

The Plan's Medi-Cal program utilizes recognized guidelines and criteria sets for utilization decision making, such as: Title 22, Title 28, Medi-Cal Managed Care Department (MMCD) Policy Letters and All Plan Letters, DHCS Provider Manuals, and, when no DHCS policy or guideline exists, the Plan follows the hierarchy of clinical criteria. Should conflicting criteria exist, the Plan is required by the state to consider Title 22 to be definitive.

Criteria for determining medical necessity are based on the needs of the individual member and the characteristics of the local delivery system. Appropriate practitioners are involved in the adoption/development and annual updates, as needed.

The criteria used in a decision that results in a denial are identified in each denial letter. Additionally, members and practitioners are informed in each denial letter how to obtain a copy of the criteria upon request as regulations apply.

The Plan's medical policies are also available at www.healthnet.com.

The Plan will use the following guidelines to make medical necessity decisions (numbered in order of significance) on a case-by-case basis, based on the information provided on the member's health status in accordance with the hierarchy noted below:

Hierarchy of Clinical Criteria

1. Federal law;

2. State law/guidelines (e.g., when state requirements trump or exceed federal requirements) including but not limited to:
   a. Title 22 CCR,
   b. Title 17 CCR,
   c. Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters
   d. California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals.
   e. Regulation SB855 and Title 28 CCR § 1300.74.721 for mental health and substance abuse (MH/SA), the most recent versions of treatment criteria developed by the nonprofit professional agencies ((i.e. American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Academy of Pediatrics, Level of Care Utilization (LOCUS)/Child & Adolescent Level of Care Utilization System (CALOCUS), WPATH etc.).

When no nonprofit professional association provides criteria for a clinical specialty, an external vendor such as InterQual or internally developed criteria may be used as long as they meet the "generally accepted standards of mental health and substance use disorder care".

3. Plan-specific clinical policy:
   a. includes custom content within InterQual® and
   b. vendor specific criteria (such as eviCore, Evolent);
4. Centene clinical policy:
   a. includes Centene customized clinical policies within InterQual;
5. Nationally recognized decision support tools:
   a. When no specific Plan clinical policy exists, tool such as Change Healthcare InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) are applied;
6. Additional considerations (no guidance from 1-5), when available:
   a. Peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
   b. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
   c. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
   d. Medical association publications;
   e. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
   f. Published expert opinions (e.g., Up-To-Date)
   g. Opinion of health professionals in the area of specialty involved;
   h. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:

- Medi-Cal benefit plan contract

- Applicable state and federal requirements
- Member Handbook/Evidence of Coverage
- Medi-Cal drug lists

Conflict Resolution

When state or federal regulation is not available to make medical necessity decisions, the Plan policy is used to define how a request is approved, modified or denied. To the extent there are any conflicts between Clinical Policy and the Benefit Plan Contract provisions or Title 22 CCR, the Benefit Plan Contract provisions and Title 22 CCR supersede.

When applying criteria to a specific individual case, the Plan considers at least the following factors:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

Characteristics of the local delivery system (if clinically necessary care is not available within the local delivery system, the Plan assists the member and practitioner to determine an alternate appropriate delivery system):

  - Ability of local hospitals to provide all recommended services within the estimated length of stay
  - Availability of skilled nursing facilities or subacute care facilities
  - Availability of other care appropriate to meet the member's individual needs

To ensure that the criteria used are consistently current, the Plan at least annually:

- Renews license agreements for the latest versions of the appropriate criteria sets, clinical practice guidelines and technology assessments
- Analyzes and updates medical criteria changes based on information collected from the previous year

Utilization management and level of care placement decisions for behavioral health and substance use disorder services are based on the criteria and guidelines set forth by the nonprofit professional associations for the relevant clinical specialty whenever possible. These sources include: Level of Care Utilization System (LOCUS)/Child & Adolescent Level of Care Utilization System (CALOCUS) criteria, American Society of Addiction Medicine (ASAM), Early Childhood Service Intensity Instrument (ECSII), Council of Autism Service Providers (CASP) and the World Professional Association for Transgender Health (WPATH). When no nonprofit professional association provides criteria for a clinical specialty internally developed criteria may be used as long as they meet the “generally accepted standards of mental health and substance use disorder care.” The Plan MAC and Quality Improvement and Health Equity Committee (QIHEC) are responsible for the review, revision and approval of all criteria.

CONTINUITY OF CARE ASSISTANCE

The Plan offers continuity of care assistance to newly enrolled Medi-Cal members for up to 12 months for eligible members. 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 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 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 apply:

- Pregnancy – for the duration of the pregnancy and the postpartum period of 12 months.
  - For members who provide written documentation of being diagnosed with a maternal mental health condition from the member's treating provider, completion of covered services will not exceed 12 months from the member's diagnosis or from the end of pregnancy, whichever occurs later.
  - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum period, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
- Surgery or procedure scheduled by a provider who is authorized by 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 from the contract termination date or 12 months from the effective date of coverage for a newly covered member.
- 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.
  - Covered for the period of time necessary to complete a course of treatment and to arrange a safe transfer to another provider. The completion of covered services must not exceed 12 months from the effective date of coverage for a newly covered member.
- 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

Medi-Cal members, their authorized representatives on file with Medi-Cal or their providers may initiate a request for continuity of care directly from the Plan. The Plan accepts verbal or written continuity of care requests.

The Plan completes continuity of care requests within:

- 30 calendar days from the date of receipt for non-urgent requests
- 15 calendar days if the member's medical condition requires more immediate attention, or
- Three (3) 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.

Upon completion of the continuity of care review, the provider and the member will be notified of the decision within seven calendar days for non-urgent requests and within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three (3) calendar days of the decision.

- If a member changes Medi-Cal managed care plans, the continuity of care period may start over one time.
- If the member changes Medi-Cal managed care plans a second time (or more), the continuity of care does not start over, meaning the member does not have the right to a new 12 months of continuity of care by the non-participating provider.
- If the member returns to Medi-Cal fee-for-service (FFS) and later re-enrolls in a Medi-Cal managed care plan, the continuity of care period does not start over.
- If a member changes managed care plans, continuity of care assistance does not extend to participating providers the member accessed through their previous managed care plan.

A request for continuity of care is complete when:

- The member is informed of their right to continued access.
- The Plan and the non-participating FFS provider are unable to agree to a compensation rate.
- The Plan has documented quality-of-care issues.

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 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, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by the Plan.
- **Health disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- **Communication** to meet the cultural and linguistic needs of all members.
- **Behavioral health aspects of care** integration by monitoring and evaluating 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, quality and safety of care and services, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.

- **Services covered by the Plan**, including preventive care; primary care; specialty care; telehealth; ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing care; home health care; long term care (TLC); long-term services and supports (LTSS); and Community Based Adult Services (CBAS), which meets the special, cultural and linguistic, complex or chronic needs of all members.
- **Internal administrative processes** related to service and quality of care, including customer service, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

QUALITY IMPROVEMENT (QI) DEPARTMENT

The QI Department establishes programs to meet regulatory requirements of the Centers for Medicare & Medicaid Services (CMS), DHCS and DMHC. These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site/medical record review audits and certification, along with any necessary follow-up corrective action plans.

This department monitors the results of QI activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also responsible for preparation and implementation of any identified corrective actions based on findings of the CMS, DHCS and DMHC audits and findings through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by individuals who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. Assigned team members are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, they are responsible for ensuring compliance with all CMS, DHCS and DMHC access-to-care standards, monitoring processes and access-to-care action plans.

QI AUDITS OF MEDI-CAL PROVIDERS

Facility Site Review and Medical Record Audits

All PCPs participating in Medi-Cal are required to complete an initial facility site inspection and subsequent periodic facility site inspections regardless of the status of the other accreditation or certifications program as part of the initial credentialing process. The full scope site review includes the facility site review (FSR), physical accessibility review survey (PARS) and the medical record review (MRR).

In an effort to decrease duplicative FSRs and MMRs, and minimize the disruption of patient care at provider offices, all Medi-Cal managed care health plans are required to collaborate in conducting FSRs and 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 corrective action plan (CAP) when necessary. The responsible plan shares the audit results and CAP with the other participating health plans. Practitioners who do not comply with a CAP or fail to meet consecutive threshold scores on an FSR or MRR are forwarded to the Credentialing Committee for administrative termination per DHCS policy. The termination will be applicable to the Medi-Cal line of business for the impacted location only and remain in effect for three years from the date of the committee's final decision. The affected practitioner is afforded rights to an informal appeal (reconsideration) of the committee's decision to administratively terminate.

DHCS reviews the results of site reviews and MRRs and may also audit a random sample of provider offices to ensure they meet DHCS standards.

DISEASE MANAGEMENT PROGRAMS

The Disease Management Program aims to identify members at risk for asthma, diabetes and heart failure. The goal of the program is to help improve the care of members with chronic conditions by empowering individuals and working with health care providers to manage their condition and prevent complications. Eligibility is based on review and analysis of claims, encounter, pharmacy, and eligibility data in compliance with the National Committee for Quality Assurance (NCQA) specifications for disease management. 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 System promotes resources and programs to educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems. Health Education programs and services include:

- **Health education resources.** Members or parents of youth members may order health education materials on a wide range of health topics, such as asthma, healthy eating, diabetes, immunizations, dental care, prenatal care, exercise and more. The materials are available in several threshold languages. Members may obtain more information by contacting the Medi-Cal Member Services Department at 888-893-1569.
- **Tobacco Cessation Program.** Kick It California (formerly California Smokers' Helpline) is a no-cost tobacco cessation program that offers specialized services for teens, pregnant smokers, individuals who chew tobacco, and e-cigarette users, and provides information on how to help a friend or family member quit tobacco use. The program is based on clinical research and proven to help you quit. Kick It California offers tailored telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English and Spanish by texting "Text "Quit Smoking" or "Quit Vaping" to 66819," a website chat function (Kickitca.org/chat), and mobile app (Available for download on the App Store® and Google Play®). Members can learn more by calling Kick It California at 800-300-8086 (English) or 800-600-8191 (Spanish), or online at www.kickitca.org.
- **Healthy Pregnancy.** Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement, and handbooks on planning a healthy pregnancy, caring for your baby, and teen parenting. High risk pregnancies receive additional case management services.
- **Diabetes Prevention Program.** Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist members in preventing or delaying the onset of type 2 diabetes.
- **Digital health education.** Members have access to online and digital resources for health education through HealthHub and our Krames online library – Resource library to help you learn about your health and how to stay healthy.
  - Health and Medications – Easy access to more than 4,000 health sheets.
  - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.
- **Teladoc mental health (digital program).** Available in English and Spanish, members have access to an evidence-based, self-help resource to improve their mental health. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, sleep problems and many other mental health conditions. This program is available at www.teladochealth.com or through the Teladoc Health mobile app.

- **Health promotion incentive programs.** Health Education partners with the Quality Improvement department to develop, implement and evaluate incentive programs to encourage members to receive health education and to access preventive health care services.
- **Community health education classes.** Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- **Community health fairs.** The Plan participates in health fairs and community events to promote health awareness to members and the community. Plan representatives provide screenings, presentations and/or health education materials at these events.

Credentialing and Recredentialing

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 Plan, federal and state regulatory requirements, and accrediting entity standards. Practitioners must be credentialed prior to providing health care services to 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 Plan or subcontracting health plans, agencies or PPGs to which credentialing responsibilities have been delegated in accordance with Plan criteria. The 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

Providers may obtain claims reimbursement more efficiently by becoming familiar with the Plan's claims procedures. This chapter covers claims, billing and encounter reporting procedures. Processes for tracking the status of a claim or requesting a claim payment adjustment are described. Provider responsibilities for coordination of benefits (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 *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, 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 FFS providers are submitted to the EDI Claims Department. An authorized vendor may be used for electronic claim submission. The 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

Coordination of benefits 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 COORDINATION OF BENEFITS CLAIM

Coordination of benefit claims must be submitted within 180 days following the date that the provider receives the other coverage's *Explanation of Benefits (EOB)*.

When the provider learns that a Medi-Cal member has other group health coverage, the provider must:

- File the provider claim with the primary carrier first.
- After the primary carrier has paid, submit a copy of the explanation of payment or *EOB* with the claim to the Plan.

COORDINATION OF BENEFITS PAYMENT CALCULATIONS

- As the payer of last resort, the 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 ID number with the other carrier.

HOW TO BILL MEDI-CAL AFTER BILLING OTHER HEALTH COVERAGE

The provider must present acceptable forms of proof to the Plan that all sources of payment have been exhausted, which may include:

- A denial letter from the other health coverage for the service.
- An EOB that shows the service is not covered by the other health coverage.

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 coordination of benefit rules. The secondary claim must be submitted with the primary remittance advice, identification and group numbers, indicating the primary 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 balance bills Medi-Cal beneficiaries for amounts in excess of any Medi-Cal required copayments and deductibles for services covered under a member's benefit program, or for claims for such services denied by the Plan or the affiliated PPG. 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 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 Submission Requirements

Providers may submit encounters to the Plan through an authorized electronic data interchange (EDI) clearinghouse, utilizing Snip level 1-5. To initiate or discuss the submission of encounter data files, contact the Capitated Claims/Encounter Department.

All professional and institutional encounters must be submitted in an electronic format.

Capitated providers are contractually required to submit complete and correct data for all professional and institutional services performed. Before submitting encounter data, the submitter should contact the Plan Encounter Department to discuss submission format and data requirements. The Plan currently accepts the ANSI 837 5010 X12 format.

All data should be submitted according to the terms of the *PPA*. If the PPG does not submit data within this time frame, the PPG is excluded from incentive programs.

Reimbursement Methods

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

For both participating and non-participating providers, the 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%.
- 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 Liability

Under Medi-Cal contracts, the 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 recovery from: tort liability of a third party; the estates of deceased members; casualty liability insurance, including workers' compensation awards and uninsured motorist coverage; or involving class action claims.

The Plan and its participating providers are required to assist DHCS in pursuing the state's right to reimbursement from such recoveries. The Plan is required to notify DHCS within 10 days of the discovery of such cases or receipt of a request from attorneys, insurers, or members of a lien using the appropriate online notification form at DHCS's Third Party Liability and Recovery Division Online Forms page at https://dhcs.ca.gov/PIForms. On request from DHCS for information, the plan must provide additional information within 30 calendar 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 Plan or the PPG in writing within five calendar days of all potential and confirmed third-party tort liability cases involving a Medi-Cal member in order for Health Net or the PPG to notify DHCS no later than 10 calendar days of the provider becoming aware of such request.
- 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 phone number of the requesting party. Notifications should be mailed to:

  Medi-Cal TPL

Recovery TPL Department
4191 East Commerce Way Sacramento, CA 95834

In all third-party tort liability cases, bill the Plan as usual, and give all details regarding the injury or illness. The 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 provider, 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 107 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 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.

Emergency-related Claim Submissions

In emergency-related situations whereby the DHCS guidelines are silent regarding claims submission, the Plan will follow the CMS coding and billing guidelines to ensure compliance and consistency in our practices.

CHAPTER 10 – 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 Plan or its participating providers. In receiving and responding to grievances, the Plan does not discriminate on the basis of race, color, national origin, ethnic group identification, ancestry, age, mental disability, physical disability, medical condition, genetic information, religion, sex, marital status, gender, gender identity, or sexual orientation. Likewise, providers shall not discriminate against members in the provision of covered services including without limitation, the filing by members of any grievance against the provider. Members may file grievances anytime about quality of care and may appeal denials of authorizations for services. Providers may also file grievances, appeal for services on the member's behalf, or dispute claim resolution and payment.

This chapter details the procedures for members and providers who wish to file grievances and appeals, matters eligible for appeal and the Plan's policy for resolving complaints.

Member Grievance Procedures

MEMBER GRIEVANCE PROCESS

A member or their physician or other representative, may file a grievance on behalf of the member anytime according to the current federal regulations, Title 42, CFR, Section 438.402(c)(i). Grievances filed by the member's physician or other representative, on behalf of the member, require written consent from the member or authorized representative. Members may submit grievances verbally or in writing by contacting the Medi-Cal Member Appeals and Grievances Department.

Members may obtain a member grievance/complaint form from their providers' office, or they may contact the CalViva Health Medi-Cal Member Services Department for assistance. The Member Grievance/Complaint forms are available online for CalViva Health Medi-Cal members

A member grievance is an oral or written expression of dissatisfaction or concern that does not involve a prior determination. Member grievances include quality of care concerns, access to care concerns, complaints regarding delays of referrals or authorizations, and provider refusals to submit medical records. There are two types of member grievances:

- Administrative – concerns of a non-clinical nature.
- Clinical – concerns of a clinical nature.

Member grievances may be submitted orally or in writing at any time. The first step in registering a grievance is to call the CalViva Health 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.

CalViva Health members are notified in writing of receipt of a grievance within five calendar days. Members are informed in writing of resolution of the grievance within 30 calendar days. If resolution of the case exceeds 30 calendar days, the Plan will send the member a letter of explanation by the 30th calendar day, documenting the reason for the delay and an estimated completion date for the resolution.

GRIEVANCE RESOLUTION PROCESS

The Plan Appeals & Grievances Case Coordinator handles the grievance and corresponds with the provider, including requesting any additional information necessary. Upon receipt, the Case Coordinator forwards the case to the Plan Clinician for review of all clinical grievances. For non-clinical grievances, the Case Coordinator will handle to resolve. In both instances the member will receive a written resolution.

Information gathered by the Plan, and as a result of the 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. Member grievances related to a request for reassignment or disenrollment of a Medi-Cal member are referred to the CalViva Health Medi-Cal Member Services Department.

MEMBER APPEAL PROCEDURE

A member appeal is a request for reconsideration of an adverse benefit determination that involves the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit. An adverse benefit determination notice is also known as Notice of Action (NOA). Member appeals may be submitted by the member, or the provider on the member's behalf, verbally or in writing, within 60 calendar days of receipt of a denial for prior authorization or receipt of an NOA to the Medi-Cal Member Appeals and Grievance Department.

Appeals filed by the provider on behalf of the member require written consent from the member. 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 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 standard 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. An NAR is a formal letter informing a beneficiary that an adverse benefit determination has been overturned or upheld.

If the Plan upholds the initial denial of coverage, the member has the following options:

- The 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 grievances and appeals process. However, the member may request an Independent IMR from the DMHC right away if the member's health is in immediate danger or if the request was denied because treatment is considered experimental or investigational; otherwise, the member must first file an appeal with the plan.
- The member may request a state hearing online, by phone or in writing from the DSS only after receiving an NAR and within 120 calendar days from the date of the NAR letter. However, if the Plan continued to provide the member with the disputed service(s) (Aid Paid Pending) during the appeal process, and the member wants to continue to receive the service until there is a State Hearing decision, the member must request a State Hearing within 10 days of the NAR. Members also have the right to representation by legal counsel, a friend or other spokesperson during the process.
- Members may ask for both an IMR and State Hearing at the same time. However, if the member asked for a State Hearing first and the hearing already took place, then the member cannot ask

for an IMR. This means the State Hearing's outcome is the final decision.

Members can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov
- By phone: 800-743-8525/TTY/TDD 800-952-8349.
- In writing: Members should fill out a State Hearing form or write a letter. Send it by mail or fax to:

  Mail: California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  Fax: 916-309-3487 or toll-free at 833-281-0903

PROVIDER-INITIATED MEMBER APPEALS

A provider or an authorized representative may submit an appeal on behalf of the member when the member is challenging a denial for a prior authorization request or a service. Appeals filed by the provider or authorized representative, on behalf of the member, require written consent from the member or authorized representative. Members have a right to access their medical records. Written authorization from the member or the member's authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or necessary in the administration of the Plan or shared with California regulatory agencies, health care providers, and health care oversight entities.

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

- The Plan processes the appeal, not the subcontractor.
- There is no second-level appeal between the Plan and the PPG. Additional appeal rights are provided in their appeal resolution letter.

MEMBER APPEALS ADDRESS

Medi-Cal Member Appeals and Grievances
Department PO Box 10348
Van Nuys, CA 91410-0348

PEER-TO-PEER REVIEW REQUESTS

The Plan aims to promote treatment that is specific to the member's condition and consistent with medical necessity, clinical practice, and appropriate level of care. An authorization request will be denied if the information provided does not meet the coverage requirements for the requested medical treatment. The Plan will notify the provider and the member of the reason for the adverse determination.

Providers may contact the Plan to discuss the adverse determination with a medical director (known as peer-to-peer review or P2P) using the instructions below.

Peer-to-peer reviews may not be used in certain situations. The peer-to-peer review does not apply to:

- Appeals. Once you or a member submit an appeal, you cannot request a peer-to-peer review. If the member submits the appeal for an adverse determination you have issued, we will reach out to you for any additional information you may have.
- Post-discharge. For adverse concurrent review determinations, you must request a peer-to-peer review prior to the member's discharge. Once the member has been discharged from a facility, you cannot request

a peer-to-peer review. If a member is discharged on the weekend, please call prior to discharge and leave a message for your peer-to-peer request to be considered timely. Beyond this time, an appeal may be filed.

- Initial adverse determinations beyond five business days. You have five business days to request a peer-to-peer review following issuance of an adverse prior authorization determination. Beyond this time, an appeal may be filed.

To request a peer-to-peer review, call the Peer-to-Peer Review Request Line at 833-236-9715. Be sure to have the following information available:

- Member name
- Member date of birth
- Case number
- Medical director name
- Name of the nurse who worked the case
- Member identification number

If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Provider Dispute and Appeal Procedures

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 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 Plan needs more information in order to process the claim.
- Challenge a request by the Plan for reimbursement for an overpayment of a claim.
- Seek resolution of a billing determination or other contractual dispute with the 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 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 Plan include challenging:

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

The 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 112, Member Appeal Procedure, for more information).

SUBMISSION OF PROVIDER DISPUTES

The Plan accepts disputes, including appeals, from participating providers if they are submitted within 365 days of receipt of the Plan's decision (for example, denial or adjustment), except as described below. If the provider does not receive a decision from the Plan, the dispute must be submitted within 365 days after the deadline for contesting or denying the claim has expired. If the provider's *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, ID number, contact information, including phone number, and the original claim number.
- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include: a clear identification of the disputed item; the date of service; and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is not about a claim, the provider must include a clear explanation of the reason for the dispute, including if applicable, relevant references to the PPA.

Providers who participate under a capitated agreement with a PPG must submit disputes to the PPG that processed the claim.

DISPUTES SUBMISSION ADDRESSES

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
CalViva Health Provider Disputes and Appeals Unit
PO Box 989881
West Sacramento, CA 95798-9881

ACKNOWLEDGMENT AND RESOLUTION

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

The 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 Plan.
- Submit a corrected claim (additional charges previously not submitted).
- Clarify member responsibility.

SUBMISSION OF PROVIDER INQUIRIES

For routine claim follow-up, providers may contact the Provider Services Department. Providers may use the following claims addresses for resubmission of contested claims with missing information (requested individual claim documents), submission of corrected claims (additional charges previously not submitted), submission of a new claim, or submission of provider appeals.

CalViva Health New Medi-Cal Claims
PO Box 9020
Farmington, MO 63640-9020

CalViva Health Contested Claims Department
PO Box 989736
West Sacramento, CA 95798-9881

CalViva Health Provider Disputes and Appeal Unit
PO Box 989881
West Sacramento, CA 95798-9881

Providers may use their own spreadsheet or form when submitting provider inquiry requests to the Medi-Cal Provider Services Department. Providers must include the following information on their spreadsheet or form to ensure appropriate research:

- Provider Full Name
- Provider Tax ID or NPI number
- Member's name
- Member's date of birth
- Member ID Card number
- Date of service
- Billed amount
- Claim number

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 Department or Medi-Cal Member Services Department to check the status of a dispute or appeal.

Provider Encounter Supplemental Dispute Procedures

The provider encounter supplemental payment dispute resolution process ensures correct routing and timely consideration of provider encounter supplemental payment disputes. Both participating and non-participating providers use this process to:

- Dispute, challenge or request reconsideration of an encounter (including a bundled group of similar encounters) that has or has not been paid by the Plan the supplemental add-on amount allowed by DHCS for DHCS Directed Payments Programs.
- Challenge a request by the Plan for reimbursement for an overpayment of an encounter supplemental add-on payment.

The Plan does not charge providers of service who submit disputes to the Plan's Direct Pay Encounter Department for processing provider disputes and does not discriminate or retaliate against a provider who uses the provider dispute process.

PROVIDER ENCOUNTER SUPPLEMENTAL PAYMENT DISPUTES SUBMISSION

The Plan accepts encounter supplemental payment disputes from participating and non-participating providers if they are submitted within 365 days of receipt of the Plan's supplemental payment, except as described below. If the provider does not receive a supplemental payment from the Plan, the dispute must be submitted within 365 days of the Plan's receipt of the encounter. If a participating provider's *PPA* provides for a dispute-filing deadline that is greater than 365 calendar days, this longer time frame will continue to apply until the contract is amended.

When submitting a provider encounter supplemental payment dispute, a provider must submit the dispute electronically to the Direct Pay Encounter Department disputes email at HNCA_EncDisputes@healthnet.com.

The provider dispute must include at minimum:

- The reason for the dispute
- Impacted tax ID number(s) and NPI(s)
- Member level detail via Excel spreadsheet including:
  - Patient name(s).
  - Date of birth.
  - CIN ID(s).
  - Dates of service.
  - CPT/HCPC(s) submitted along with any modifiers.
  - Patient control number/PPG claim number.

ACKNOWLEDGMENT AND RESOLUTION

The Plan acknowledges receipt of each provider encounter supplemental payment dispute received electronically via email within two business days of receipt.

If the provider encounter supplemental payment dispute submission does not include all pertinent details of the dispute, it is returned to the provider with a request detailing the additional information required to resolve the issue. The amended dispute must be submitted with the missing information within 30 business days from the date of receipt of the request for additional information.

The Plan resolves each provider dispute within 45 business days following receipt and sends the provider an electronic determination stating the reasons for the determination.

GLOSSARY

Appeal. Also known as a dispute, a request for reconsideration of an initial determination for prior authorization of a service, or for the denial or adjustment of a claim.

Authorization. Approval requested and obtained by providers for designated service before the service is rendered. Used interchangeably with prior authorization.

Beneficiary Identification Card (BIC). A plastic card issued by the state to recipients of entitlement programs which is used by contractors to verify the Plan's eligibility. Eligibility files are updated monthly.

California Children's Services (CCS). A state and county program providing medically necessary specialized medical care and rehabilitation to those under age 21 with physically handicapping conditions defined in Medi-Cal law, and who meet medical, financial and residential eligibility requirements for the CCS program.

California Work Opportunities and Responsibility to Kids (CalWORKs). A state program that provides temporary financial assistance and employment-focused services to families with minor children who have income and property below state maximum limits for their family size.

Department of Mental Health (DMH). The state agency that sets policy and administers the delivery of community- based public mental health services statewide.

Department of Health Care Services (DHCS). The state agency responsible for administration of the Medi-Cal, Comprehensive Perinatal Services Program (CPSP), CCS, and other health-related programs.

Drug Medi-Cal Program Services (D/MC). The program administered by the California Department of Mental Health to provide medically necessary drug abuse services to Medi-Cal beneficiaries who meet the eligibility criteria defined in Medi-Cal law. Services include assessment, crisis intervention, group and individual counseling, naltrexone treatment services, perinatal residential drug abuse services, outpatient methadone maintenance services, and day care rehabilitative services.

Eligible Beneficiary. Any Medi-Cal beneficiary residing in the service area of a Medi-Cal contractor and who qualifies for one of the following categories (with a specific aid code): CalWORKs, Medically Needy Family, Seniors and Persons with Disabilities (SPD) population, Medically Indigent Child, Medically Indigent Adult, and Refugee.

Emergency Care. The provision of medically necessary services required for the immediate alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Lack of such care could lead to disability or permanent damage to the patient's health if not diagnosed and treated without delay.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens Program. An initial, periodic or additional health assessment of an eligible individual under age 21 is provided in accordance with Medi-Cal law. The program consists of periodic and interperiodic screening services, and diagnostic and treatment services, including care management services.

Fee-for-Service (FFS). A method of charging based upon billing for a specific number of units of services rendered to an eligible beneficiary. FFS is the traditional method of reimbursement used by physicians, and payment almost always occurs retrospectively.

Grievance. An expression of dissatisfaction regarding access to care or quality of care problems by a member or provider.

Health Maintenance Organization (HMO). An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed-upon set of comprehensive health maintenance and treatment services for an enrolled group through a predetermined periodic fixed prepayment.

Indian Health Service (IHS) Facilities. Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

Medical Records. A confidential document containing written documentation related to the provision of physical, social and mental health services to a patient.

Medically Necessary. Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member. An eligible beneficiary who has enrolled in a 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 and Screening Services for Children and Youth Under Age 21. Preventive care screening program for eligible beneficiaries under age 21 as provided in Medi-Cal law. Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens Supplemental Services and the Prenatal Guidance Program.

Preventive Care. Health care designed to prevent disease and its consequences. There are three levels of preventive care: primary, such as immunizations aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy aimed at restoring function after disease has occurred.

Primary Care. A basic level of health care usually rendered in ambulatory settings by general practitioners,

family practitioners, internists, obstetricians, pediatricians, and mid-level providers. This type of care emphasizes caring for the member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Physician (PCP). A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP has focused the delivery of medicine to general practice or is a board-certified or board-eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner.

Quality Assurance (QA). A formal set of activities to assure the quality of clinical and non-clinical services provided. QA includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process. The Plan's participating providers (including delegated providers) are contractually required to participate in all timely access surveys administered by or on behalf of regulatory agencies such as the DHCS, DMHC and CMS.

Rape and Sexual Assault. Under California law, rape and sexual assault generally involve non-consensual sexual acts. Below is a simple breakdown as derived from the California Penal Code (PC), which can be accessed in detail through the California Legislator.

- Rape (PC 261, 263, 263.1): Non-consensual sexual intercourse accomplished through force, threats, fraud, or when the victim is unable to give consent due to intoxication, unconsciousness, or mental incapacity.
- Consent (PC 261.6): A voluntary, freely given agreement to engage in sexual activity. Lack of resistance does not imply consent.
- Sodomy and oral copulation (PC 286, 287): Engaging in anal or oral sex without consent, using force, threats, or exploiting a victim's inability to resist.
- Sexual acts with a child (PC 288.7): Any sexual intercourse, sodomy, or oral copulation with a child under 10 years old is a felony.

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: rape and other sexual assault, drug or alcohol abuse, pregnancy, family planning, pregnancy termination, mental health, and sexually transmitted infections designated by the director of DHCS for children ages 12 or older.

Urgent Care. Medically necessary services provided for an unforeseen illness or injury required to prevent the serious deterioration of health. Treatment of the illness or injury requires professional attention that cannot be delayed for longer than 48 hours, or disability or permanent damage to the patient's health could result.

Utilization Management (UM). A formal, prospective, concurrent, or retrospective critical examination of appropriate use of segments of the health care system, such as hospitalization, clinics, provider services, emergency departments, skilled nursing facilities, and home care.

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