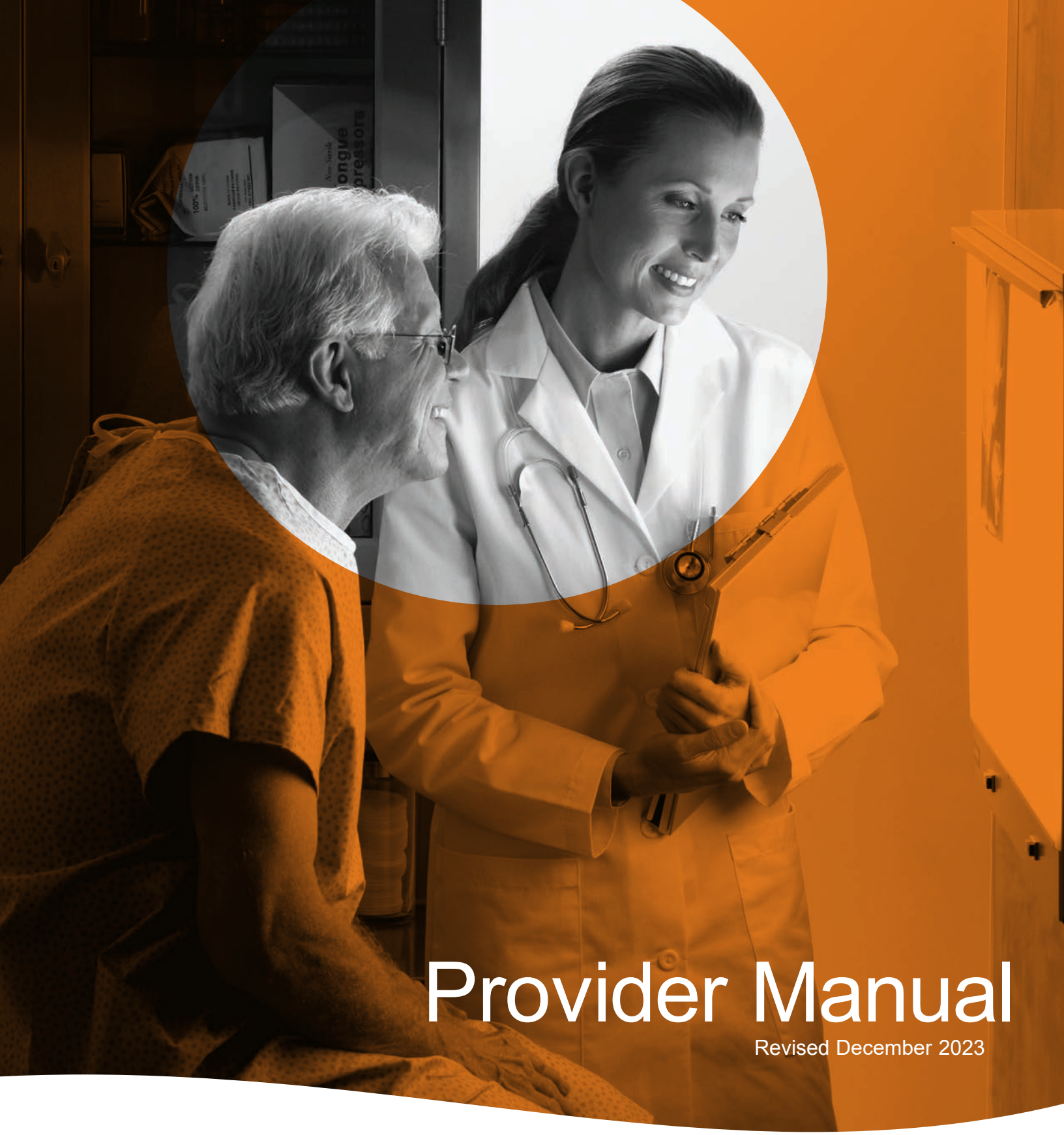


Provider Manual

Revised December 2023

CAHealthWellness.com

california health & wellness™

CALIFORNIA HEALTH & WELLNESS PLAN – QUICK REFERENCE GUIDE

Resource	Contact
Website	www.cahealthwellness.com
Mailing Address	California Health & Wellness Plan 4191 East Commerce Way Sacramento, CA 95834
Provider Services	Phone: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) FAX: (877) 302-3434
Secure Provider Portal	www.cahealthwellness.com - click on "login" in the "For Providers" box on the right hand side of the page
Provider Data Reporting and Validation Form	Online: www.cahealthwellness.com under Provider Resources Email: CAProvData@cahealthwellness.com Phone: (877) 658-0305
California Health & Wellness Plan Eligibility IVR Line (24/7 availability)	(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) - follow the menu options to reach the automated member eligibility-verification system
State Automated Eligibility Verification System (AEVS)	(800) 456-2387 or https://www.medi-cal.ca.gov/Eligibility/TimeOut.asp?GoBack=Eligibility.asp
Prior Authorization	Phone: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) FAX: (866) 724-5057
Physician-Administered Medication Prior Authorizations	Phone: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) FAX: (866) 724-5057
Medi-Cal Rx	Phone: 800-977-2273 FAX: 800-869-4325 Website: medi-calrx.dhcs.ca.gov **CoverMyMeds Online Prior Auth Form: covermymeds.com**
AcariaHealth Specialty Pharmacy	Phone: (855) 535-1815 (For TTY, contact California Relay by dialing 711 and provide the 1-855-535-1815 number) FAX: (855) 217-0926
ClaimsMedi-Cal Rx Help Desk	Phone: 800-977-2273

Envolve Vision Care	Phone: (800) 531-2818 FAX: (866) 614-4951 General Network Management email: EBONM@envolvehealth.com Website: visionbenefits.envolvehealth.com
Envolve Vision Care Claims Submission Details	**Paper Claims Submission:** Envolve Vision Attn: Claims Department P.O. Box 7548 Rocky Mount, NC 27804 **Electronic Claims Submission:** Change HealthCare Payor ID 56190 Claims assistance phone: (800) 334-3937
Nurse Advice Line (24/7 Availability)	(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
Interpretation, Translation, and Disability Access Services	(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
Claims	(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
Paper Claims Submission Address	California Health & Wellness Attn: Claims P.O. Box 4080 Farmington, MO 63640-3835
Assistance with Electronic Claims Submission & Rejection Detail	(800) 225-2573, ext. 6075525 Or by email to: EDIBA@centene.com
Claims Dispute Submission	California Health & Wellness Plan Attn: Claim Disputes PO Box 4080 Farmington, MO 63640-3835
HEDIS Questions	HEDIS_help@cahealthwellness.com
American Specialty Health Group, Inc. (ASH) Acupuncture Services	Website: www.ASHLink.com Phone: 1-800-972-4226 Join ASH Network Phone: (888) 511-2743
ASH Claim Submission Details	**Paper Claims Submission:** American Specialty Health Group, Inc. Attn: Claims Department P.O. Box 509001 San Diego, CA 92150-9001

	Electronic Claims Submission: Change HealthCare Payor ID 43146
Contracting Inquiries	California Health & Wellness Plan Attn: Contracting 4191 East Commerce Way Sacramento, CA 95834 Email: CHWP_Contracting@cahealthwellness.com FAX: 1-855-463-4107
MHN – Behavioral Health Service	844-966-0298 for behavioral health (BH) service referrals and any general inquiry assistance related to BH services Website: www.mhn.com Behavioral Health Provider Relations, clinical training request, contracting related inquiries: MHN.ProviderServices@Healthnet.com Professional.Relations@MHN.com
MHN Behavioral Health Services Claims Submission Details	**Paper Claims Submission:** MHN Attn: Claims Department PO Box 14621 Lexington, KY 40512-4621 **Electronic Claims Submission:** Change HealthCare Payor ID 22771
Health Information Programs	Information line: 1-800-804-6074

Contents

CHAPTER 1: INTRODUCTION

Welcome

Welcome to California Health & Wellness Plan. We appreciate having you as our provider partner. Together we can improve the health of our communities, one person at a time. You are a valuable part of California Health & Wellness Plan's network of participating physicians, hospitals and other healthcare professionals. **Our number one priority is the promotion of healthy lifestyles through preventive healthcare.** California Health & Wellness Plan works to accomplish this goal by partnering with the providers who oversee the healthcare of California Health & Wellness Plan's members.

About California Health & Wellness Plan

California Health & Wellness Plan is a managed care organization (MCO) contracted with the California Department of Health Care Services (DHCS) to serve California Medi-Cal enrollees. Since our launch in 2013, we have been committed to positively transform the communities in which we live, work and serve through improved access to quality healthcare and support services. Through locally-grounded, coordinated care and support services, California Health & Wellness Plan is focused on improving the health of our members. California Health & Wellness Plan serves individuals in 19 rural counties under the state's Medi-Cal Managed Care Program. We apply our expertise in working with enrollees to improve their health status and quality of life. California Health &Wellness Plan is a wholly owned subsidiary of Centene Corporation, a national leader in healthcare services for more than 30 years.

Our Mission

Headquartered in Sacramento with offices in Chico, El Centro, Placerville and San Diego, California Health &Wellness Plan invests in the communities we serve through community engagement, health education programs and partnerships. The California Health & Wellness Plan board of directors, leadership and staff are dedicated to improving the health of our members through focused, compassionate and coordinated care in collaboration with our providers and other stakeholders. Together, we work diligently so that members receive the right care, in the right place, at the right time. We are committed to transforming the health of the community, one person at a time. Our mission is to provide better health outcomes at lower costs. We are driven by the following beliefs:

- We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enable meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities.

California Health & Wellness Plan strives to improve health status, foster successful outcomes, and attain high member and provider satisfaction. California Health & Wellness Plan's service model has been designed to achieve the following goals:

- Ensure access to primary and preventive care services.
- Support care delivery in the best setting to achieve an optimal outcome.
- Improve access to all necessary healthcare services.
- Encourage quality, continuity and appropriateness of medical care.
- Provide medical coverage in a cost-effective manner.

All of our programs, policies and procedures are designed with these goals in mind. We are happy to have you as part of our network and thank you for assisting us in reaching our goals.

Non-Discrimination Notice

California Health & Wellness Plan follows state and federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

California Health & Wellness Plan provides:

- Free aids and services to people with disabilities to communicate better with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If a Member needs these services, please have them contact California Health & Wellness Plan's Customer Contact Center at: **1-877-658-0305** (For TTY, contact California Relay by dialing 711 and provide the Member Services number: **1-877-658-0305**). If a member believes that California Health & Wellness Plan has failed to provide these services or discriminated in another way, they can file a grievance by calling the number above and asking for help filing a grievance; the California Health & Wellness Plan Customer Contact Center is available to help.

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F HHH Building, Washington, DC 20201, 1-800–368–1019, (TDD: 1-800–537–7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Getting Assistance from California Health & Wellness Plan

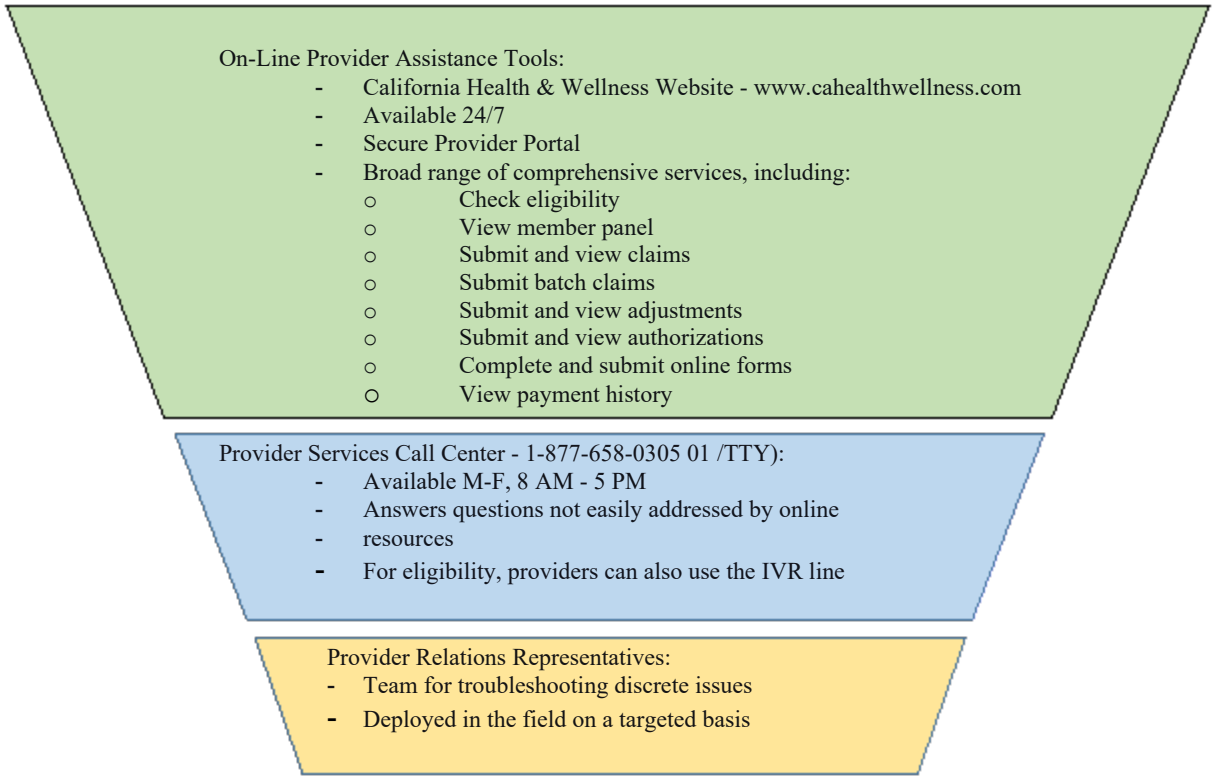
When you have questions or need assistance, we encourage you to first use the many resources that we have available for providers on the California Health & Wellness Plan website (www.cahealthwellness.com) and on our secure Provider Portal. You will always be able to obtain assistance 24 hours, 7 days per week using these online resources. Furthermore, to help you get the most value out of these online tools, throughout the Provider Manual we highlight and explain the key resources and tools available on the California Health & Wellness Plan website and secure Provider Portal, including screenshots and tips on how to use these tools.

If you are not able to easily locate the answer to your questions using our online provider resources and this Provider Manual, you can also contact our Provider Services department at **(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).** Our Provider Services Call Center is available Monday – Friday from 8 a.m. to 5 p.m. and can answer questions not easily addressed by our online resources.

Please also see Chapter 2 ("Provider Resources") of this Manual for California Health & Wellness Plan contact information regarding specific topics.

Additionally, California Health & Wellness Plan also has a team of Provider Network Specialists, who are deployed in the field and are assigned to address targeted issues. In some cases, one of our Provider Network Specialists may work with you to troubleshoot a specific issue that is difficult to resolve.

The diagram below shows how our provider resources are deployed, and where you can go for help:



What's in This Manual?

California Health & Wellness Plan is committed to working with its provider community and members to deliver a high level of satisfaction with quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to California Health & Wellness Plan's operations, benefits, and policies and procedures for providers.

We have organized the Manual's contents to highlight subjects of greatest interest to our providers, including:

- Authorization and Referral Guidelines.
- Claims and Billing Guidelines.
- Eligibility Verification and Enrollment.
- Pharmacy and Prescriber Information.
- Services Covered or Administered by California Health & Wellness Plan.
- Services Covered by Other Agencies.

If you have any questions, please contact Provider Services at 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 877-658-0305 number).

Where to Find and How to Navigate the Manual

This Provider Manual is posted on our website at www.cahealthwellness.com where providers can review and print it free of charge. Providers will be notified of material changes to the Provider Manual via bulletins and notices posted to California Health & Wellness Plan's secure website and in its weekly Explanation of Payment notices.

Electronic Manual - The electronic version of the Manual is set up for easy navigation. Simply click on the "bookmark" icon on the left-hand side of the Provider Manual. This will open up a set of bookmarks for the topics covered in the Manual. Alternately, you can use the "find" function (CTRL-F) within Acrobat to search by key word.

Printable Chapters - The Manual has been designed so that you can easily create printable "pull out" chapters as a reference. To print out an individual chapter, click on the "bookmark" icon on the left-hand side of the Provider Manual. This will expand the panel to show a Chapter List. Right-click on the chapter you wish to print and a context menu will pop up. Select "Print Page(s)."

For hard copies or CD copies of this Provider Manual, or if you need further explanation on any topics discussed in the provider Manual, please contact the Provider Services Department at **(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).**

CHAPTER 2: RESOURCES FOR PROVIDERS

The following chart contains important contact information and resources that are available for your office. The tables below not only include important contact information for California Health & Wellness Plan, but also key State and county-level contacts. When calling California Health & Wellness Plan, please have the following information available:

- NPI (National Provider Identifier) number.
- Tax ID Number (TIN) number.
- California Health & Wellness Plan member's ID (Medi-Cal member's ID number).

California Health & Wellness Plan Information		
California Health & Wellness Plan 4191 East Commerce Way Sacramento, CA 95834 Phone: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) www.cahealthwellness.com		
Provider Data Reporting and Validation		
Online: www.cahealthwellness.com under Provider Resources Email: CAProvData@cahealthwellness.com Phone: (877) 658-0305		
Department	**Telephone Number (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)**	**Fax Number**
Provider Services	(877) 658-0305	(877) 302-3434
Member Services	(877) 658-0305	(877) 302-3434

Automated Eligibility Verification System (AEVS)	(800) 456-2387	Not Applicable
Admissions	(877) 658-0305	1-855-556-7907
Case Management	(877) 658-0305	1-855-556-7909
Concurrent Review	(877) 658-0305	1-855-556-7910
Prior Authorization – Medical Services	(877) 658-0305	1-866-724-5057
Claims	(877) 658-0305	Not Applicable
Appeals and Grievances	(877) 658-0305	1-855-460-1009
Payment Disputes	(877) 658-0305	Not Applicable
Nurse Advice Line (24/7 Availability)	(877) 658-0305	Not Applicable
MHN Services (Outpatient Mental Health)	844-966-0298 www.mhn.com	844-974-0492
Prior Authorization: High Tech Radiology (MRI/CT/PET)	(877) 658-0305 www.radmd.com	(877) 302-3434
To report suspected waste, fraud, or abuse to California Health & Wellness Plan	1-866-685-8664	Not Applicable
Medi-Cal Rx	800-977-2273	800-869-4325
Envolve Vision Care visionbenefits.envolvehealth.com By email: EBONM@envolvehealth.com	(800) 531-2818	(877) 940-9243
Non-Emergent Medical Transportation (PCS required) and Non-Medical Transportation	(877) 658-0305	Not Applicable

www.cahealthwellness.com		
Interpretation, Translation, and Disability Access Services	(877) 658-0305	Not Applicable
Ethics and Compliance Hotline	(800) 345-1642	Not Applicable

Claim Submission Address	Claim Dispute Submission
California Health & Wellness Plan Attn: Claims PO Box 4080 Farmington, MO 63640-3835	California Health & Wellness Plan Attn: Claim Disputes PO Box 4080 Farmington, MO 63640-3835

For assistance with Electronic Claims Submissions
California Health & Wellness Plan c/o Centene EDI Department (800) 225-2573, ext. 6075525 Or by e-mail to: EDIBA@centene.com

State Resources	
Automated Eligibility Verification Service (AEVS)	(800) 456-2387
Department of Health Care Services Medi-Cal Managed Care Ombudsman	1-888-452-8609
Department of Health Care Services Office of Family Planning	(800) 942-1054
Medi-Cal Telephone Service Center	(800) 541-5555
Denti-Cal	(800) 423-0507

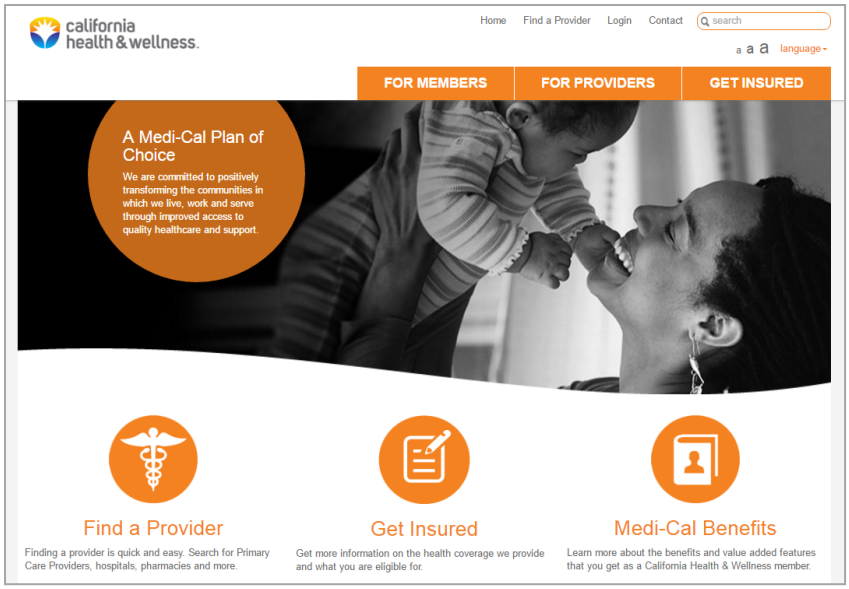
California Department of Health Care Services (DHCS)	(916) 445-4171
California Department of Managed Health Care (DMHC)	1-888-466-2219

Provider Resources on the California Health & Wellness Plan Website

The California Health & Wellness Plan website can significantly reduce the number of telephone calls providers need to make to the health plan. The website allows immediate access to current provider and member information 24 hours, seven days a week. Please contact our Provider Services Department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) with any questions or concerns regarding the website.

California Health & Wellness Plan's website is located at www.cahealthwellness.com. Providers can find the following information on the public website:

- Provider Manual
- Provider Billing Manual
- Information regarding electronic transactions
- "Pre-Auth Needed?" Tool to determine if a prior authorization is required (by entering a CPT, HCPCs or Revenue code)
- Pharmacy Information
- Forms
- California Health & Wellness Plan News
- Clinical Guidelines
- Provider Bulletins
- Provider Newsletters
- Member Handbook
- "Find a Provider" tool to identify California Health & Wellness Plan contracted providers



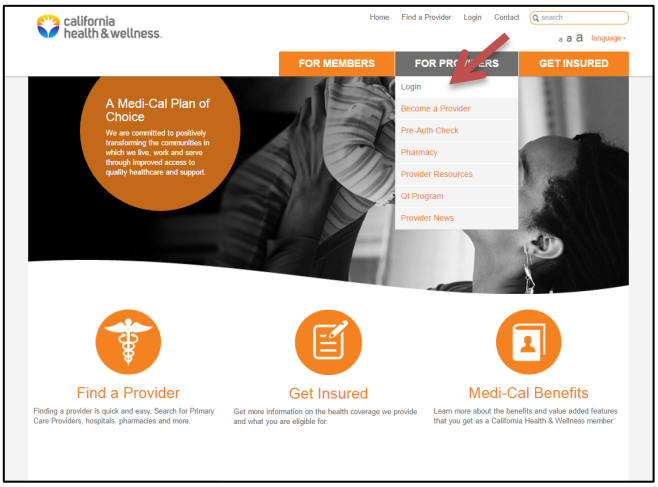
Secure Provider Portal

The California Health & Wellness Plan secure provider website enables providers to check member eligibility and benefits, submit and check status of claims, submit claims adjustments, request authorizations, and send messages to communicate with California Health & Wellness Plan staff. California Health & Wellness Plan' contracted providers and their office staff can register for our **secure provider website quickly and easily**. We offer tools that make obtaining and sharing information easy, and using the Portal is both simple and secure.

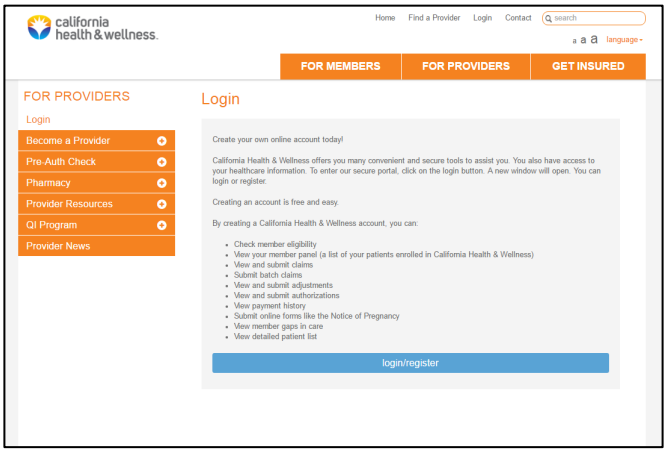
To register, go to www.cahealthwellness.com. On the home page, select the "Login" link on the top right to start the registration process. A step-by-step registration overview is provided below. Further instructions including an instructional video are available on our website and can be accessed by using the following link: provider registration video.

Secure Provider Portal Registration Process:

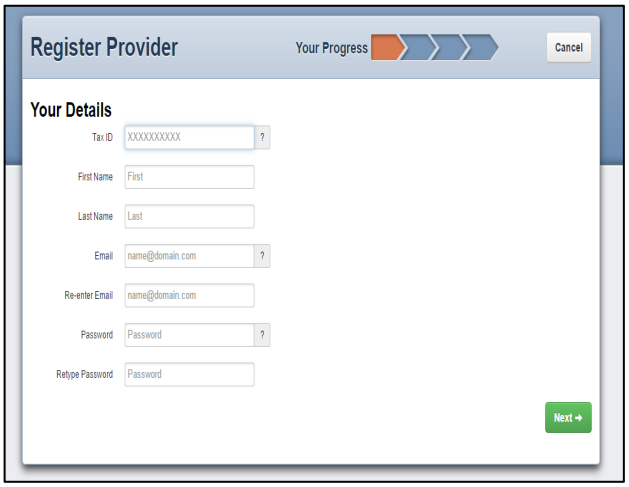
1) Browse the public website and select “Log-in” under the “For Providers” Section



2) Click the blue “login/register” button.



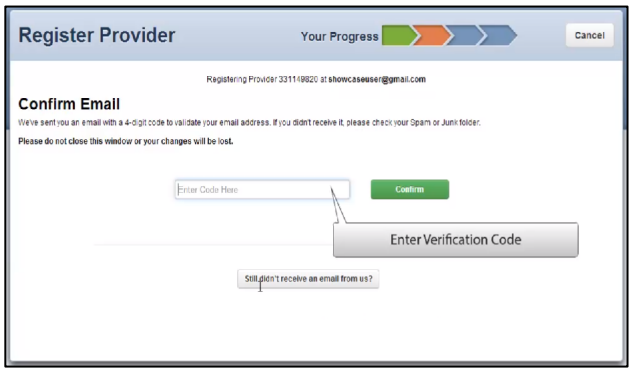
3) Click “Create an Account” to start the registration process. Enter your Tax ID, name, e-mail address and create your own password. Hover over the “?” symbol for more details. Click ‘Next’.



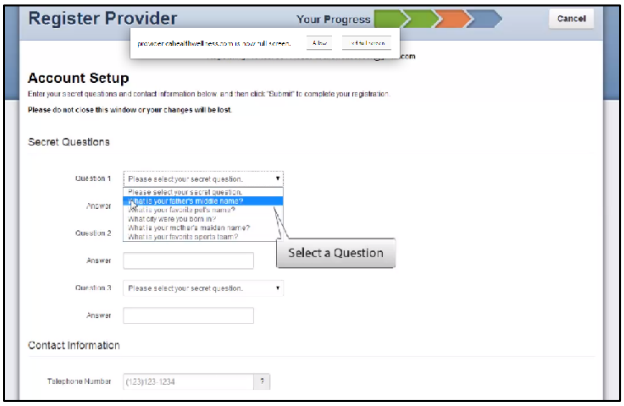
(NOTE: If you receive the following error message: “We could not find your Tax ID in our system”, please return to the “Become a Provider” page on our website to join the network. As an alternative, you can submit your first claim using an EDI vendor, or submit a claim on paper. Once your provider data has been

entered in our data system, you should be able to create an account.)

4) Leave the registration window open while you wait for a provider confirmation email. You will receive an email with a security code; please enter the security code and submit.



5) Complete the security questions and contact information. Once this information has been submitted, this information is forwarded to California Health & Wellness Plan for approval. You should receive an email and have access to the provider website within 2 business days.



Once registered, a California Health & Wellness Plan Provider Relations Representative is available to provide instructions on how to view and submit authorizations, create and submit claims requests, and to view the provider's panel using the Provider Portal.

In addition to the features mentioned above, you may also:

- View members' health records
- View the PCP panel (patient list)
- View payment history
- View a quality scorecard
- Contact us securely and confidentially

We continuously update our website with the latest news and information, so save our address to your Internet "Favorites" list and check our site often. You may sign up as soon as your contract is completed. Once you sign up, instructions are available on the site to answer many of your questions.

Provider Relations

The California Health & Wellness Plan Provider Relations Department continuously trains, educates and keep providers and their staff up-to-date on:

- Physician and office staff initial and ongoing education and training (California Health & Wellness Plan shall conduct initial training orientation within 10 business days of providers having an active status)
- Provide an overview of our different provider and member programs and services offered, such as provider incentives, free transportation and language assistance
- Distribution of provider tools, such as provider reference materials, provider communications and the provider manual which we distribute no later than seven calendar days after the provider joins our network
- Secure web-based provider portal features and navigation training
- Secret shopper evaluations
- On site quality reviews
- Provision of information on provider performance with respect to quality indicators measured by California Health & Wellness Plan and engagement of provider staff in quality improvement activities, special projects or initiatives, such as HEDIS®
- Assistance addressing changes within your practice (i.e., changes in office staff, new location, practice TIN, name, demographics, language or service capabilities, addition or termination of providers, or panel status)
    - Quarterly updates of changes in your language capabilities, or that of your office staff, are required
- Monitor network adequacy so that our members have sufficient access to care that mirrors community access standards, and to maintain compliance with the California Department of Health Care Service's access standards
- Occasional provider surveys regarding referral network or preferences with regard to certain providers to target for participation into our network

Provider Relations is avidly focused on HEDIS improvement. These efforts are centered on supporting eligible providers with quality improvement projects, building strategic plans for fulfilling HEDIS services. This can include an overview of the provider's point of care appointment process, tracking systems and practices, medical record documentation training, coordination of one-stop clinics and immunization registry education, among other topics.

Providers seeking a formal training, which can be completed in-person or otherwise coordinated and is related to any of the items listed above, can initiate their request by contacting the Provider Services Call Center and have their request submitted to the Provider Relations Department. Our Provider Services Call Center is available to assist with general questions and inquiries that are not easily addressed by our online resources by calling 1-877-658-0305. (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number), Monday - Friday 8 a.m. - 5 p.m.

CHAPTER 3: ELIGIBILITY

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

- Log on to the secure Provider Portal at www.cahealthwellness.com. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medi-Cal ID and date of birth. Please note that you must request access to the secure website by visiting the web in order to access information via the secure Provider Portal. Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the methods below to verify member eligibility for each date of service.

- Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods below to verify member eligibility for each date of service.

- Check the State's Automated Eligibility Verification System (AEVS). If the member has not received his/her California Health & Wellness Plan member identification card, check the state of California's AEVS system to check a Medi-Cal beneficiary's eligibility and health plan enrollment information. To verify coverage using AEVS, log on to: https://www.medi-cal.ca.gov/Eligibility/TimeOut.asp?GoBack=Eligibility.asp and follow the on-screen instructions, or swipe the member's state-issued Medi-Cal Beneficiary ID (BIC) card using the Medi-Cal Point of Service (POS) device.

- Call our automated member eligibility IVR system (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). From any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24-hours a day. The automated system will prompt you to enter the member Medi-Cal ID and the month of service to check eligibility.

- Call California Health & Wellness Plan Provider Services. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name or member's Medi-Cal ID to verify eligibility.

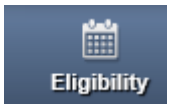
How to Check Eligibility Using the Secure Provider Portal

We encourage providers to use our secure Provider Portal at www.cahealthwellness.com to verify member eligibility. This Portal is available 24 hours a day, 7 days per week. Follow these instructions to verify eligibility using our secure Provider Portal:

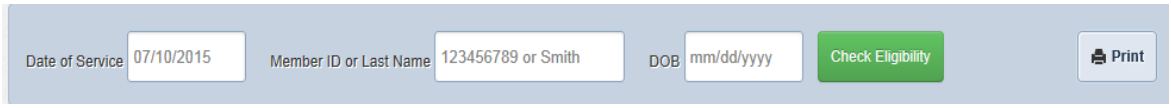
- Enter www.cahealthwellness.com on your browser
  - From the main landing page of www.cahealthwellness.com, click on "login" in the "For Providers" box on the right hand side of the page

- Click on "login" on the Provider Login page, and enter your username and password
  - If you have not already registered for access to the secure Provider Portal, register on the Provider Login page

- Select the Eligibility key in the center header of the home screen



- Enter the Date of Service, member ID number or Last Name and DOB in the applicable boxes. Select Check Eligibility



How to Check Eligibility Using California Health & Wellness Plan's IVR Line

To use California Health & Wellness Plan's automated IVR line, call (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) and follow the instructions. Providers can enter the requested information by providing verbal responses when prompted.

Importance of Checking California Health & Wellness Plan Eligibility Systems in Addition to Checking AEVS

We recognize that some providers prefer to check the state of California's Automated Eligibility Verification System (AEVS) or check the state's POS system using the member's Beneficiary ID Card. If a provider elects to verify eligibility using either AEVS or the POS system, we strongly recommend that the provider also check California Health & Wellness Plan's eligibility system by logging into the secure Provider Portal on www.cahealthwellness.com, calling our member eligibility IVR, or contacting our Provider Services' call center. It is important to check the California Health & Wellness Plan's eligibility system because it has the most current status of the beneficiary's eligibility if the member is enrolled in our plan, and also has other important information regarding the member's care.

When checking eligibility through California Health & Wellness Plan's secure provider web Portal, providers are able to identify the member's PCP. In addition, PCPs are able to access a list of eligible members who selected them as their primary care provider or have been assigned to them. The

member list is reflective of all changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Children's Health and Disability Prevention (CHDP) exam. This information is available through California Health & Wellness Plan's secure Provider Portal, but is not available on AEVS.

What to Do if California Health & Wellness Plan Eligibility System and AVES Results Differ

In some limited cases, the eligibility information on California Health & Wellness Plan's eligibility system may not match the information on state's AEVS or POS system. In such cases, providers should use the eligibility information from the state's AEVS POS system to confirm eligibility and health plan assignment. The state's AEVS is the primary source of eligibility, and should be followed to validate coverage if there is a discrepancy between the California Health & Wellness Plan eligibility system and AEVS. Providers may also contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) for answers to additional eligibility questions.

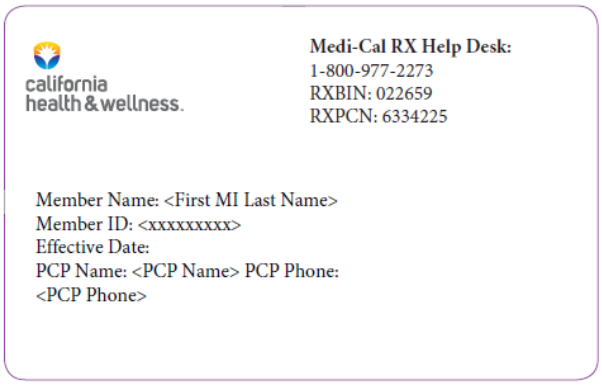
Member Identification Card

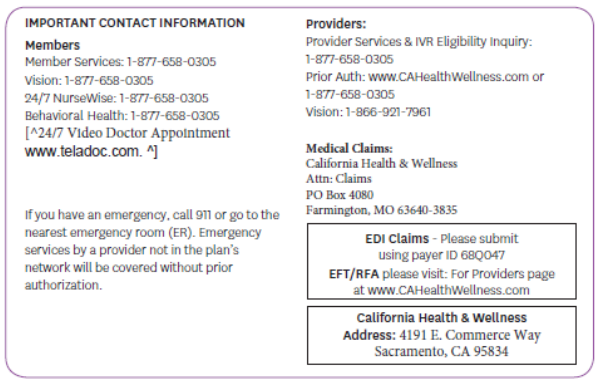
All new California Health & Wellness Plan members receive a California Health & Wellness Plan member ID card. The member ID card will include the following information:

- The member's Name
- The member's Medi-Cal Number
- The effective date
- The PCP's name and phone number
- Medi-Cal Rx phone number
- The California Health & Wellness Plan name
- The Member Services number (Monday to Friday, 8 a.m. to 5 p.m.): 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 877-658-0305 number)

A new card is issued only when a member reports a lost card, has a name change, requests a new PCP or for any other reason that results in a change to the information disclosed on the ID card. **Since member ID cards are not a guarantee of eligibility, providers must verify members' eligibility on each date of service.**

Whenever possible, in addition to their California Health & Wellness Plan ID card, we recommend providers ask members to present a photo ID card each time non-emergent services are rendered. If you suspect fraud, please contact Provider Services at 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) immediately.





These are sample ID cards only. The information included in them is subject to change. Providers should refer to a member's ID card when they present for services for current benefit and health plan information.

Member Disenrollment Procedure

This section contains general information and procedures regarding member disenrollment requirements.

The following document applies only to Independent Practice Association (IPA), Hospitals, and Ancillary Providers.

A member may disenroll at any time and without cause by contacting the Health Care Options (HCO) at 800-430-4263 (TTY 800-430-7077 or 711) to request disenrollment between 8:00 a.m. and 6:00 p.m. Monday through Friday or visit http://www.healthcareoptions.dhcs.ca.gov/. Allow up to 30 days to process the request. Members can also contact the HCO to check on status of their request.

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

The disenrollment process may take 15 to 45 days to complete. California Health & Wellness Plan continues to be responsible for the member's health care until disenrollment is approved. The Department of Health Care Services (DHCS), not the Plan, approves all such requests.

Disenrollment is mandatory under the following conditions:

- Loss of Medi-Cal eligibility

- The member is placed in a Medi-Cal waiver program by California Health & Wellness Plan's Health Care Services department.
- Enrollment had violated the State of California's marketing or enrollment laws, rules or regulations.
- Member has moved outside of the California Health & Wellness Plan's approved service area.
- Member is assigned to a Waiver Program
- Member's Medi-Cal status changes to an ineligible aid code

Provider Request to Disenroll a Member

To request disenrollment of a member, providers must contact the California Health & Wellness Plan Member Services Department. Providers are asked to describe the circumstances leading them to request the disenrollment and may be asked to submit documentation regarding their requests.

On notification, the California Health & Wellness Plan Medi-Cal Member Services Department shall contact the member and provide counseling. If necessary, the department reassigns the member to a new primary care physician (PCP) within the plan. If reassignment is not possible and the member requires disenrollment based on the guidelines outlined below, the Plan Medi-Cal Member Services Department sends the information to the Department of Health Care Services (DHCS) for approval or disapproval of the disenrollment request. Once the disenrollment has been approved, a letter is sent to the member.

A provider-initiated disenrollment request, based on the breakdown of the provider-member relationship, is considered good cause and is approved by DHCS 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.
- The member is disruptive to provider operations in general.
- The member habitually uses providers not affiliated with California Health & Wellness Plan for non-emergency services without required authorizations.
- The member has allowed fraudulent use of the California Health & Wellness Plan's identification card to receive services from Plan providers.

Failure to follow prescribed treatment, including failure to keep appointments, is not, in itself, good cause for disenrollment, unless California Health & Wellness Plan and the provider can demonstrate to DHCS that, as a result of such failure, the Plan or provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated.

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

Process for Requesting Termination or Transfer

All Levels of Behavior

Formally document each incident of unacceptable behavior on the Transfer/Termination (T/T) Incident Report form (PDF) and fax to California Health & Wellness Plan Member Services at **877-302-3434** or mail to:

California Health & Wellness Plan Member Services
740 Creekside Oaks,
Sacramento, CA 95833.

Include documentation of any counseling sessions with the member regarding unacceptable behavior and any follow-up written notifications. If the counseling session is documented in the member's medical record by the physician, physician assistant (PA) or registered nurse practitioner (RNP), attach a copy of this documentation to the T/T Incident Report. Incidents of unacceptable behavior can often occur in rapid succession, so it is important that the Independent Practice Association (IPA) remain current in its discussions and notification letters. Incidents must be documented as they occur, not retroactively.

When a primary care physician (PCP) or specialist determines that he or she is unable to continue to provide care to a member because the patient-physician relationship has been compromised and mutual trust and respect are lost, a just-cause member transfer may be appropriate. In the United States, the treating physicians and IPAs must always work within the code of ethics established through the American Medical Association (AMA). For information regarding the AMA code of ethics, refer to the AMA website at www.ama-assn.org.

Under the code of ethics, the physician must provide the member with notice prior to discontinuing as the treating physician to enable the member to contact the plan and make alternate care arrangements. However, prior to sending such notice, physicians must also coordinate such transfers with their IPAs' administration department. The plan conducts a fair investigation of the facts before any involuntary transfer for any reason is carried out.

Legally, the Plan cannot consider termination unless the IPA or PCP follows the proper procedures outlined below for the applicable level of behavior. The plan must have time for follow-up communication with the member and must allow the member a reasonable time to respond.

- When sending the notification letters and T/T Incident Report, you must include all documentation relating to the incident. The plan and the IPA must have thorough documentation of each occurrence as a former member may take legal action. To ensure that all documentation is current, it is important for the PCP to go through the IPA administration department in contacting the plan.

- Any T/T Incident Report received by the California Health & Wellness Plan Member Services department, without a copy of the member notification letter is considered incomplete and is returned to the originating PCP or IPA.
- The Plan will assess the member's warning level and any possible transition of care concerns.
- A copy of the T/T Incident Report is forwarded to the appropriate provider relations and contracting specialist (formally provider network administrator).
- The plan must receive the member's statement within 20 calendar days from the time of the Plan's receipt of the IPA's notification letter to allow the Plan an opportunity to mediate the situation informally

Level A Behavior

Level A behavior is:

- Failure to pay the required copayments after at least two billings. The copayment balance (if applicable) must exceed $50 before the plan considers transfer of the member.
- Three missed appointments within 12 consecutive months without timely cancellation.

Level A behavior must occur at least three separate times within 12 consecutive months and persist despite the following warnings of both the IPA and the Plan to warrant termination:

- First occurrence of level A behavior - The IPA must counsel the member, including asking for the member's perspective, and document the counseling session. A letter must be written to the member indicating that such behavior is unacceptable. If the member is under age 18, the subscriber must be notified of the incident. It is recommended that the letter be sent by registered mail with return receipt requested. The IPA is required to keep a copy of the letter and the Transfer/Termination (T/T) Incident Report (PDF).

In addition, a copy of the letter, documentation and the T/T Incident Report must be mailed or faxed to the California Health & Wellness Plan Member Services Department at **877-302-3434** or mail it to:

California Health & Wellness Plan Member Services
1740 Creekside Oak Drive
Sacramento, CA 95833

The provider relations and contracting specialist (formally provider network administrator) must receive a copy of the T/T Incident Report.

- Second occurrence of level A behavior -- The IPA takes the same action as with the first occurrence. At this point, the Plan sends the member a warning letter outlining the behavior problem and the possible consequences if the behavior persists.
- Third occurrence of level A behavior -- The IPA may request, in writing, a transfer or termination of the subscriber or member from the contract. The Plan reviews the IPA documentation outlining the continued unacceptable behavior.

The Plan is allowed up to 60 calendar days to mediate the situation again on receipt of the second warning letter.

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage.

Level B Behavior

Level B behavior is:

- A provider's request to transfer a member to another provider if the member and current provider cannot agree on a treatment plan (note: members have the right to refuse care), and after reasonable notification is made to the member and an alternate provider is obtained
- Disruptive or abusive behavior exhibited to the PCP office staff, a referral physician, or a hospital emergency department. This behavior must be deemed so disruptive or abusive that the physicians involved determine that the member-physician relationship has deteriorated to such a level that it cannot be resolved satisfactorily for both parties

Level B behavior must occur twice to two different providers in the IPA within 12 consecutive months to warrant termination from the IPA. Upon first occurrence, the IPA must counsel the member, including asking for the member's perspective, and write to the member stating that such behavior is unacceptable. The counseling session must be documented. Mail or fax a copy of the letter, documentation of the incident and a copy of the Transfer/Termination (T/T) Incident Report (PDF) to the California Health & Wellness Plan Member Services Department at **877-302-3434** or mail it to:

California Health & Wellness Plan Member Services
1740 Creekside Oak Drive
Sacramento, CA 95833

A copy of the T/T Incident Report is sent to the provider relations and contracting specialist (formally provider network administrator). The IPA keeps a copy of the letter and the T/T Incident Report. The Plan sends the member a warning letter, outlining the behavior problem and the possible consequence (termination) if such behavior persists.
For Level A or B behavior, the Plan is allowed up to 60 calendar days after receipt of the request for transfer or termination (sent only after the above procedure for the previous occurrence is followed) before the subscriber is officially notified of the transfer or termination. This is to allow the plan adequate time to:

- Review the supporting documentation.
- Allow legal counsel to review the case, if needed.
- Attempt another informal transfer or removal of the member.
- Allow the Case Management Department and regional medical director review as appropriate.

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage.

Level C Behavior

Level C behavior is:

- Fraudulently applying for any benefits under the Plan contract.
- Dangerous behavior exhibited while seeking or receiving care (for example, threatened or attempted physical abuse of IPA staff or other patients). There must be an eyewitness to the occurrence who is willing to document the incident in writing.
- Receipt of a notice of a subscriber's intent to pursue legal action. Refer to the Just-Cause Request to Transfer discussion under the Guidelines for Transfer discussion for additional information.

Level C behavior need only occur once for the IPA to request immediate transfer or termination. The IPA must formally document the incident, including written notification to the member. Mail or fax the IPA's transfer or termination request with all supporting documentation to California Health & Wellness Plan Member Services Department. As this is the Plan's first awareness of a problem with the subscriber or member, and given the seriousness of level C behavior, the Plan is allowed up to 60 calendar days to review the case and respond. During this time, the Plan may:

- Obtain legal counsel to determine the validity of the charge (fraud cases).
- Inform the member by certified mail that the IPA has requested transfer or termination and offer the member an opportunity to respond.
- Inform the provider relations & contracting specialist (formally provider network administrator) of the incident.
- Examine documentation to determine if transfer or termination is warranted with assistance from the regional medical director, Legal Department and Case Management Department, as appropriate.

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage, except in the case of fraudulent activity.

Eligibility Categories Covered by California Health & Wellness Plan

The California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) have oversight authority and manage the provision of healthcare services for all Medi-Cal managed care beneficiaries. The DHCS has contracted with California Health & Wellness Plan to build and maintain provider networks for those who qualify for the state's Medi-Cal program.

Below is a summary of Medi-Cal eligibility categories that are covered by California Health & Wellness Plan:

Temporary Assistance for Needy Families (TANF)

- Seniors and Persons with Disabilities (SPD)
- Medicaid Covered Expansion (MCE)
- Older Adult Expansion (OAE)
- Supplemental Security Income (SSI)
- SSI-linked Dual Eligibles (SSI Duals)
- Foster Care

California Health & Wellness Plan's Service Area

The California Health & Wellness Plan service area includes the following 19 counties in California:

Alpine	Colusa	Inyo	Placer	Tehama
Amador	El Dorado	Mariposa	Plumas	Tuolumne
Butte	Glenn	Mono	Sierra	Yuba
Calaveras	Imperial	Nevada	Sutter	

CHAPTER 4: BENEFIT EXPLANATION AND LIMITATIONS

California Health & Wellness Plan Benefits

California Health & Wellness Plan network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number), Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

California Health & Wellness Plan covers, at a minimum, those core benefits and services specified in our Agreement with the California Department of Health Care Services. **California Health & Wellness Plan members may not be charged or balance billed for covered services.**

Medical Services

This list is not intended to be an all-inclusive list of covered and non-covered benefits. All services are subject to benefit coverage, limitations, and exclusions as described in the plan coverage guidelines. Some services require prior authorizations. The participants are not responsible for any cost sharing for covered services. For more information on services requiring Prior Authorization – please check the "Pre-Auth Check" page on our website.

Service	Coverage	Details and Limitations
Abortion	Covered	Some services require certain diagnosis and modifier restrictions; for more information, please use the following link: abortion services.
Acupuncture	Covered	As of July 1, 2016 Acupuncture is covered by the health plan. Send acupuncture claims to: American Specialty Health Group, Inc. Claims Department PO Box 509001 San Diego, CA 92150-9001 Acupuncture
Adult Day Health Services/Adult Day Health Centers (ADHS/ADHC)	Covered	Limitations apply. ADHS/ADHC is also referred to as Community Based Adult Services (CBAS), which is described further in this Manual. The description can be accessed using this link: CBAS.
Adverse childhood experiences (ACEs) screening	Covered	To receive payment for screening Medi-Cal patients for ACEs on or after July 1, 2020, Medi-Cal providers must take required training, self-attest to having completed training and use approved screening tools. Contracted providers must match the correct HCPCS code based on the score and description of the screening performed. Clean claims must be received within one year from the date of service. Payments for codes G9919 or G9920 are made within 90 calendar days of receipt. The medical plan is financially responsible. All providers delivering ACEs services need to submit their claims to CHWP. • Under age 21, permitted for periodic ACE rescreening as determined appropriate and medically

Service	Coverage	Details and Limitations
		necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1] • Age 21 through age 64, Permitted once in their adult lifetime (through age 64), per clinician (per managed care plan). Screenings completed while the person is under age 21 do not count toward the one screening allowed in their adult lifetime. Adults should be screened at least once in adulthood, and though ACEs occur in childhood (by definition) and therefore do not change, patient comfort with disclosure may change over time, so re-screening for adults may be considered.[1] For more information on these approved directed payments for ACEs screening, refer to DHCS All Plan Letter (APL) 19-018, distributed on December 26, 2019, and Medi-Cal Bulletin 547, dated January 2020, and APL 23-017.
Alcohol Misuse Screening and Behavioral Counseling	Covered	Providers are required to include alcohol misuse screening and behavioral counseling services annually for Medi-Cal members ages 18 and older The Department of Health Care Services (DHCS) requires the use of the following validated screening tools: • The Alcohol Use Disorder Identification Test (AUDIT) • The Alcohol Use Disorder Identification Test-Consumption (AUDIT-C), or A single-question screening, such as asking, "How many times in the past year have you had (for women and all

Service	Coverage	Details and Limitations
		adults ages 65 and older) four or (for men) five or more drinks in a day?"
Alcohol and Substance Abuse Treatment Services (including drugs used for treatment and outpatient heroin detoxification services)	Not covered by the Health Plan	Refer to Medi-Cal for limits by using the following link: Drug Medi-Cal Treatment Program link. Please bill the state for these services. Providers are responsible for referring members who meet criteria for alcohol and drug disorders to a county drug program for services. These services are not covered by CHWP. A list of substance use disorder (SUD) services is available on the DHCS website.
Allergy Services (testing and desensitization)	Covered	Limits applicable when office visits billed in conjunction with allergy services. For more information, please use the following link to the Medi Cal Manual: allergy services.
Alphafetoprotein Testing Program Laboratory Services	Not covered by the Health Plan	Please bill the state directly for these services.
Ambulance – Emergency Transportation	Covered	Fixed-wing transport requires prior authorization (subject to medical necessity). Rotary wing transport requires prior authorization.
Ambulance - Non-emergency medical transportation (PCS required)	Covered	Call Member Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) to arrange for services. Please also see a full description of the non-emergency medical transportation later in this chapter (NEMT).
Ambulatory Surgery Center - ASC	Covered	Must be billed on UB – 04 (or successor form). ASC services billed on a CMS (HCFA) form will be denied as not billed on appropriate form.

Service	Coverage	Details and Limitations
Anesthesia Services	Covered	Please check the specific procedure using the online "Pre-Auth Needed?" Tool to see if authorization is required. Use this link to navigate to the "Pre-Auth Needed?" Tool.
Applied Behavioral Therapy	Covered	See Behavioral Health Treatment (BHT) benefit. Services provided in the school setting are covered by the school district.
Artificial Insemination	Not covered by the Health Plan	
Audiology Services	Covered	Limited to Audiologist providers only. Prior authorization is not required for services rendered by participating providers. Frequency limits vary by procedure. Please use the following link to the Medi-Cal Manual for specific requirements: audiology services. For members under age 21, refer to California Children's Services (CCS) guidelines using this link: audiology services. Scroll down and look for the section on "Recipients Under Age 21".
Autism Therapy	Covered	See Behavioral Health Treatment (BHT) benefit. Services provided in the school setting are covered by the school district.
Bariatric Surgery	Covered	Requires prior authorization. Only covered in a CMS Certified Center of Excellence. Other limits apply. For more information, please use the following link to the Medi-Cal Manual: bariatric surgery.
Behavioral Health Treatment (BHT) for Autism Spectrum Disorder	Covered	Members do not qualify for BHT services if they: • Are not medically stable; or • Need 24-hour medical or nursing services; or

Service	Coverage	Details and Limitations
		• Have an intellectual or developmental disability (ID/DD) and need procedures done in a hospital or an intermediate care facility (ICF/ID). If members are currently receiving BHT services through a Regional Center, the Regional Center will continue to provide these services until a plan for transition is developed. Further information will be available at that time. Members can call California Health & Wellness Plan if they have any questions or ask their Primary Care Provider for screening, diagnosis and treatment of ASD. Services provided in the school setting are covered by the school district
Biofeedback	Not covered by the Health Plan	
Birthing Centers	Covered	Limitations may apply. For more information, please use the following link to the Medi-Cal Manual: birthing centers.
Blood and Blood Derivative Products	Covered	Limitations may apply, please use the following link to the Medi-Cal Manual: blood products
Blood Pressure Equipment (DME)	Covered	There are diagnosis restrictions and modifier requirements. Limitations may apply for diagnosis restrictions, please use Medi-Cal Manual (use the following link to the Medi-Cal Manual: DME. Appropriate modifiers are needed if the DME is a Rental or Purchase. Personal, home-use blood pressure monitors and blood pressure cuffs for use with personal, home blood pressure monitoring devices are a covered benefit under Medi-Cal Rx as a pharmacy-billed item. Refer to the list of

Service	Coverage	Details and Limitations
		covered personal blood pressure monitoring devices and blood pressure cuffs found on the Medi-Cal Rx website at medi-calrx.dhcs.ca.gov.
Bone Density Testing	Covered	Limitations apply: One test per year for specified diagnoses. Not covered if provided for screening purposes only.
Breast Pumps (DME)	Covered	Modifier requirements apply. Limitations may apply. Please use the following link to the Medi-Cal Manual: DME. Also, will need appropriate modifiers if the DME is a Rental or Purchase.
California Children's Services (CCS) Program medical services for children with certain special health problems	Covered by California Children's Service Program	Use the following link for more information about CCS limits: CCS; or use the following link to obtain contact information for the DHCS Children's Medical Services Division, which administers the CCS program: CCS Contacts.
Certified Nurse Midwife	Covered	Please use the following link for more information about limitations: Certified Nurse Midwife limitations
Chemotherapy	Covered	For members under age 21, please refer to CCS guidelines using the following link: CCS Chemotherapy. Also contact the DHCS Children's Medical Services for more information – use the following link for more information: CCS Contacts. CCIPA: Chemotherapy (including adjunctive therapy) is covered by CH&W.

<table>
<tr><th>Service</th><th>Coverage</th><th>Details and Limitations</th></tr>
<tr><td>Chiropractic Services</td><td>Covered</td><td>Only covered by the Health Plan when services are rendered at a Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC). Please
bill
the state Medi-Cal program for services rendered at any other place of service.

The following information is required for appropriate billing of chiropractic services.

• Must be billed with place of service (POS) 50 to indicate the service was provided at an FQHC/RHC.
• Primary diagnosis must indicate chiropractic-related care. Primary diagnosis must be indicated by an approved chiropractic diagnosis code from the ICD-10-CM table below. If the relevant diagnosis code is not in the primary diagnosis code position, the claim will be denied.
• CPT code must be one of the codes shown in the CPT code table below. Evaluation and management (E&M) codes are not reimbursable.

<table><tr><th>CPT code</th><th>Type of visit</th><th>Maximum allowance</th></tr><tr><td>98940</td><td>Chiropractic manipulative treatment (CMT); spinal, one to two regions</td><td>$16.72</td></tr></table></td></tr>
</table>

Service	Coverage	Details and Limitations

98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions	$16.72
98942	Chiropractic manipulative treatment (CMT); spinal, five regions	$16.72

ICD-10-CM CODE	DESCRIPTION
M50.11–M50.13	Cervical disc disorder with radiculopathy
M51.14–M51.17	Intervertebral disc disorders with radiculopathy
M54.17	Radiculopathy, lumbosacral region
M54.31, M54.32	Sciatica
M54.41, M54.42	Lumbago with sciatica
M99.00–M99.05	Segmental and somatic dysfunction

<table>
<tr><th>Service</th><th>Coverage</th><th>Details and Limitations</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>S13.4</td><td>Sprain of ligaments of cervical spine</td></tr>
<tr><td>S16.1</td><td>Strain of muscle, fascia and tendon at neck level</td></tr>
<tr><td>S23.3</td><td>Sprain of ligaments of thoracic spine</td></tr>
<tr><td>S29.012</td><td>Strain of muscles and tendon of back wall of thorax</td></tr>
<tr><td>S33.5</td><td>Sprain of ligaments of lumbar spine</td></tr>
<tr><td>S33.6</td><td>Sprain of sacroiliac joint</td></tr>
<tr><td>S33.8</td><td>Sprain of other parts of lumbar spine and pelvis</td></tr>
<tr><td>S39.012</td><td>Strain of muscle, fascia and tendon of lower back</td></tr>
</table>
For more information, please use the following link: Chiropractic.
</td></tr>
<tr><td>Child Health and Disability Prevention (CHDP) Services</td><td>Covered</td><td>Covered for members ages 0 through 20 years and 11 months. While providers are strongly encouraged to do so, providers do not have to enroll in VFC. However, providers will not be reimbursed for serum, if serum is available from VFC. Non-enrolled VFC providers will only be reimbursed for an administration fee for any vaccine that can be obtained in the VFC program. For more information, please use the following link to</td></tr>
</table>

Service	Coverage	Details and Limitations
		the Medi-Cal VFC Manual: Medi-Cal VFC.
Christian Science Practitioners	Not covered by the Health Plan	Contact the state Medi-Cal Program directly for more information. Use the following link to obtain state Medi-Cal program contact information: state Medi-Cal contact.
Circumcision – Medically Necessary	Covered	
Circumcision – Routine/Elective	Not covered by the Health Plan	
Clinical Trials	Not covered by the Health Plan	Please contact your California Health & Wellness Plan Provider Network Specialist for more specific information.
Cognitive Health Assessment	Covered	Medi-Cal providers must take required training, self-attest to having completed training and use approved screening tools to receive payment for conducting an annual cognitive health assessment for eligible members age 65 or older and who are not eligible for a similar assessment as part of an annual wellness visit under the Medicare program. For more information on billing and payments for annual cognitive assessments, see the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025, distributed on November 28, 2022. **Training** You are eligible to receive the payment if you comply with both of the following:[1] • Finish and attest to completing the cognitive health assessment

Service	Coverage	Details and Limitations
		training, as specified and approved by the DHCS. Training is available at the Dementia Care Aware website. • Conduct the cognitive health assessment using a tool suggested by the DHCS. **Assessment tools** At least one cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:[1] • Patient assessment tools - General Practitioner assessment of Cognition (GPCOG) - Mini-Cog • Informant tools (family members and close friends) - Eight-item Informant Interview to Differentiate Aging and Dementia - GPCOG - Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) Based on the scores from these assessments, additional assessment or a specialist referral may be appropriate. [1]Information taken or derived from DHCS APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older. www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf.
Community Based Adult Services (CBAS)	Covered	Limitations apply. CBAS is described further in this Manual,

Service	Coverage	Details and Limitations
		and the description can be accessed using this link: CBAS.
Comprehensive Perinatal Services Program	Covered	Limitations may apply. Providers must bill the correct codes, using the Local Z codes. See the following link for more information: CPSP.
Cosmetic Surgery (not medically necessary)	Not covered by the Health Plan	For more information, please use the following link: Medi-Cal Surgery Manual.
Dental (dental services provided by dental providers)	Not covered by the Health Plan	Covered by Denti-Cal. Use the following link to obtain more information regarding Denti-Cal: Denti-Cal.
Dental (medical services related to dental services – provided by medical providers)	Covered	Laboratory services Pre-admission physical examinations Facility fees /anesthesia both inpatient / outpatient Please check specific codes on the "Pre-Auth Needed?" Tool for authorization requirements. To access the "Pre-Auth Needed?" Tool, use the following link: "Pre-Auth Needed?" Tool.
Diabetic Services	Covered	For members under age 21, refer to CCS guidelines by using the following link: CCS guidelines; or contact the DHCS Children's Medical Services using contact information at the following link: CCS Contacts.
Dialysis	Covered	For members under age 21, refer to CCS guidelines by using the following link: CCS guidelines.

Service	Coverage	Details and Limitations
Directly Observed Therapy (DOT)	Not covered by the Health Plan	Covered by the Medi-Cal fee-for-service program and County Health Departments. DOT is a specific tuberculosis (TB) treatment rendered by Local Health Departments. For more information about state Medi-Cal coverage, use the following link: Tuberculosis.
Durable Medical Equipment (DME)	Covered	Certain limits apply, including diagnosis and modifier limits. More limits may apply depending on the specific code. For more information about applicable limits, please use the following link to the Medi-Cal Manual: DME.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered	Covered only for Members age 20 years and younger
Emergency Room Services	Covered	
Enteral Nutrition	Covered	Home Infusion (requiring pump): Covered through medical benefit Bolus/Gravity/Oral: Covered through Medi-Cal Rx pharmacy benefit For members under age 21, refer to CCS guidelines by using the following link: CCS guidelines; or contact the DHCS Children's Medical Services using contact information at the following link: CCS Contacts.
Parenteral Nutrition	Covered	For members under age 21, refer to CCS guidelines by using the following link: CCS guidelines; or contact the DHCS Children's Medical Services using contact

Service	Coverage	Details and Limitations
		information at the following link: CCS Contacts.
Home Infusion	Covered	For members under age 21, refer to CCS guidelines by using the following link: CCS guidelines; or contact the DHCS Children's Medical Services using contact information at the following link: CCS Contacts.
Erectile Dysfunction	Covered	Erectile dysfunction diagnostic evaluation is the only covered service. Erectile dysfunction drugs and therapies are NOT covered.
Experimental Services (other than those provided in covered clinical trials)	Not covered by the Health Plan	This includes, but is not limited to drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans.
Family Planning Services (and supplies)	Covered	Please refer to Medi- Cal using the following link: Family Planning.
FQHC – Federally Qualified Health Center services	Covered	
Fluoride Varnish (non-dental provider)	Covered	Only covered for members under age 6. Covered three times in a 12-month period. Attending physicians or nurses must provide the service.
Gender Reassignment Surgery	Covered	Covered only for members age 18 and over. Procedures that are not medically necessary are not covered.
Health Education	Covered	Coverage limited for pregnancy services only. Please see use this

Service	Coverage	Details and Limitations
		link for more information from the Medi–Cal Manual: CPSP.
Hearing Aids and Repairs	Covered	Limitations may apply. For members under age 21, refer to CCS guidelines by using the following link: Hearing Aids.
Hearing Screenings	Covered	Other limitations may apply. For more information, use the following link: Hearing Screenings. For members under age 21, refer to CCS guidelines by using the following link: Newborn Screening Program.
HIV Testing and Counseling	Covered	
Home and Community Based Services (HCBS) – Waiver Programs	Not covered by the Health Plan	Check with the state Medi-Cal program to determine coverage. For more information about state Medi-Cal program coverage, use the following link: HCBC.
Home Health Care Services	Covered	Limitations may apply For more information, use the following link: Home Health Services.
Hospice Care	Covered	Inpatient hospice services require prior authorization.
Hospital Services – Inpatient	Covered	Please check specific codes on the online Pre-Auth Needed" tool to determine if authorization is required. The "Pre-Auth Needed?" Tool is available at the following link: "Pre-Auth Needed?" Tool.
Hospital Services – Outpatient	Covered	Please check specific codes on the online Pre-Auth Needed" tool to

Service	Coverage	Details and Limitations
		determine if authorization is required. The "Pre-Auth Needed?" Tool is available at the following link: "Pre-Auth Needed?" Tool.
Hyperbaric Oxygen Therapy – HBO	Covered	For members under age 21, refer to CCS guidelines here: CCS; or contact the DHCS Children's Medical Services using contact information at the following link: CCS Contacts.
Hysterectomy	Covered	Only covered when medically necessary. Not covered if performed only to make a member permanently sterile. For more information, use the following link: Hysterectomy.
Immunizations Adults	Covered	For more information on availability through the pharmacy benefit, contact Medi-Cal Rx.
Immunizations Children	Covered	For more information, use the following link to the Vaccine/Immunization guidelines: VFC Guidelines. When free vaccines are available, as under the VFC program, the Health Plan only pays the administration fee for those vaccines.
Incontinence Creams and Washes	Covered	Subject to age and modifier requirements. Please use the following link for more specific information: Incontinence
Indian Health Programs	Covered	Services provided by tribal clinics and Indian Health Service (IHS) facilities are covered as long as the services are a Medi-Cal covered service. Use the following link to locate an Indian

Service	Coverage	Details and Limitations
		Health Program facility: Find a Provider. Claims: Use the CMS-1450 (UB-04) form for all claims billed directly to CHWP rather than one of their specialty service vendors. Use the UB-04 with revenue codes and CPT/HCPCS codes. Revenue codes and CPT/HCPCS codes must be taken from the Indian Health Service – Memorandum of Agreement (IHS-MOA) Code Conversion Table found on the California Department of Health Care Services website. For IHS claims for specialty services vendors, use the forms indicated below: • American Specialty Health, Inc. (acupuncture claims): CMS-1500 • Envolve Vision (vision services): CMS-1500 • MHN (behavioral health): UB-04http://files.medi-cal.ca.gov/pubsdoco/hipaa/articles/IHS-MOA_Code_Conversion_Crosswalk_25407_01.pdf

Infertility (diagnosis and treatment)	Not covered by the Health Plan	Infertility services are not a covered benefit. Please use this link to refer to the Medi-Cal Manual for more information: infertility.
Injectable Medications	Covered	Limits apply to certain medications. Please check specific codes on the online Pre-Auth Needed" tool to determine if authorization is required. The "Pre-Auth Needed?" Tool is available at

		the following link: "Pre-Auth Needed?" Tool. Self-administered injectables: covered through the Medi-Cal Rx pharmacy benefit Provider-administered injectables: covered through the medical benefit. • CCIPA: CCIPA covers all provider-administered medications except for chemotherapy (including adjunctive therapy) and transplant immunosuppression. The CHWP website Pharmacy page contains the injectable medication HCPC/DOFR crosswalk to determine provider-administered "therapeutic" vs. self-administered injectables.
Intellectual Disabilities Services (ID/DD) Services	Not covered by the Health Plan	Regional Centers contract with the California Department of Developmental Services to provide or coordinate services and supports for individuals with intellectual or developmental disabilities. Health Plan covers/arranges for primary care and other medically necessary services, and coordinates with the Regional Centers.
Interpreter Services (including Sign Language)	Covered	Must bill specific codes. Use the following link to obtain more information: Sign Language and Interpreter Services. Services provided in the home or by a non-participating provider require prior authorization.

Investigational Services	Not covered by the health plan	Please contact your California Health & Wellness Plan Provider Network Specialist for more specific information.
Laboratory and Pathology Services (inpatient and outpatient place of service settings)	Covered	Some limitations apply. Please contact your California Health & Wellness Plan Provider Network Specialist for more specific information. Quest Diagnostics® and LabCorp® are the preferred providers for laboratory services.
Laboratory Services - State Serum Alphafetoprotein Testing Program	Not covered by the Health Plan	Please bill the state directly for these services.
Local Educational Agency (LEA) Services	Not covered by the Health Plan	Please bill the state Local Educational Agency program directly for these services For more information on Medi-Cal limits, use the following link: LEA.
Long-Term Care (LTC)	Covered by the Health Plan.	Long-term care (LTC) is care in a facility, including skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities Refer to Medi-Cal for limits here: Long-Term Care. Use the Long-Term Care Authorization Notification Form (PDF) to request authorization. Please note: Hospice services are not considered LTC. To request authorization for hospice services, a separate Outpatient (OP) Authorization is required and must include the hospice agency and the facility that

		the member is residing in at time of services.
Mammography (screening)	Covered	Requires prior authorization for women under age 40 and over age 74. Prior authorization is not required for women age 40 – 74.
Maternity	Covered	Limitations may apply. Must bill the correct codes, using the Local Z codes. Use the following link to obtain more information: Maternity.
Mental Health Services – Mild to Moderate Conditions	Covered	Certain Outpatient Mental Health Services for treatment of mild to moderate mental health conditions are covered. Services for relational problems are not covered. Refer to the Behavior Health chapter 13 of this Manual.
Mental Health Services – Moderate to Severe Conditions	Not covered by the Health Plan	All moderate to severe mental health conditions are billed to the state. Please submit claims to the state.
Mental Health Services – Inpatient Services	Not covered by the Health Plan	All inpatient Mental Health Services are to be billed to the state.
Non-Emergency Medical Transportation (NEMT), Non-Medical Transportation (NMT)	Covered	Call Member Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) to arrange for services. Please also see a full description of the non-emergency medical transportation later in this chapter (NEMT).
Non-Medical Equipment	Not Covered by the Health Plan	Includes items that are not medically necessary and are primarily for comfort or convenience.

Obstetrical/Gynecological Services including pap smears (routine/preventative)	Covered	
Ostomy Supplies	Covered	
Oxygen and Respiratory (services, supplies, equipment)	Covered	
Pain Management	Covered	Requires Prior authorization - Limits include, but are not restricted to, specific diagnoses
Pap Smears (routine/preventative)	Covered	For more information, see the cervical cancer screening recommendations from the US Preventive Services Task Force: USPSFT Cervical Cancer.
Pediatric Day Health Care	Not covered by the Health Plan	For more information about state Medi-Cal coverage of pediatric day health care, use the following link: Pediatric Day Health Care.
Personal Care Services	Not covered by the Health Plan	For information about the state's In-Home Supportive Services program, please use the following link: IHSS; for information about state-administered home and community-based alternatives, please refer to the following link: HCBS.
Personal comfort items	Not Covered	
Physical, Occupational and Speech Therapy	Covered	Please check specific codes on the online "Pre-Auth Needed" tool to determine if authorization is required. The "Pre-Auth Needed?" Tool is available at the following

		link: "Pre-Auth Needed?" Tool. For members under age 21, refer to CCS guidelines by using the following link: MTP.
Physician, Registered Nurse Practitioner, or Physician Assistant Services	Covered	Please use the following link to identify restrictions associated with billing for Nurse Practitioners, Physician Assistants and Mid Wives: NP, PA, CNM
Podiatry Services	Covered	Modifier and CPT code restrictions apply. Please use the following link for more information on allowed podiatry codes: podiatry codes.
Prayer or Spiritual Healing	Not covered by the Health Plan	
Pregnancy Services	Covered	
Prescription Drugs	Covered	Medi-Cal Rx program
Preventive Care Services	Covered	Services for children and adults include, but are not limited to; preventative health assessment visits, well child care, screenings (e.g.: pap smears, mammograms, total serum cholesterol, etc.), and immunizations.
Prosthetic and Orthotic Devices and Specialized footwear	Covered	For members under age 21, refer to CCS guidelines by using the following link: Orthotics and Prosthetics.
Radial Keratotomy	Not covered by Health Plan	
Radiation Therapy	Covered	For members under age 21 refer to CCS guidelines by using the following link:

		CCS; or contact the DHCS Children's Medical Services using the contact information at the following link: CCS Contacts.
Radiology Services (high-tech imaging)	Covered	MRI, MRA, CAT and PET. For more information, please use the following link: NIA.
Radiology Services (all services other than high-tech imaging)	Covered	
Reconstructive Surgery (non-cosmetic)	Covered	Some limits apply. For members under age 21, refer to CCS guidelines by using the following link: CCS Eligibility and see item M.
Rehabilitative Services	Covered	
Rural Health Clinic	Covered	
Services not allowed by federal or state law	Not covered by the Health Plan	
Sexually Transmitted Diseases (STD) – screening and treatment	Covered	
Skilled Nursing Facility (SNF)	Covered	Prior authorization required.
Specialist Physician Consultations	Covered	
Sterilization Services	Covered	Covered only for members age 21 & older. Consent form is required with claim submission. Form can be accessed by using this link: Sterilization Consent Form. Please use the following link to the Medi-Cal Manual for information on policy restrictions: sterilization.

Subacute Care Facilities		Members in need of adult or pediatric subacute care services must be placed in a health care facility that is under contract for subacute care with the California Department of Health Care Services (DHCS) Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with SCU. In order to receive Medi-Cal subacute care reimbursement, a provider must be contracted with DHCS as per CCR, title 22, section 51215.6 (a) which states "Adult subacute services and pediatric subacute services shall be provided by a licensed general acute care hospital with distinct-part skilled nursing beds or a freestanding certified nursing facility that enters into a contract with the Department." This requirement ensures that facilities receiving Medi-Cal subacute care reimbursement meet certain standards and that members residing in these facilities do not experience disruptions in access to care. In order for facilities to receive Medi-Cal reimbursement, they must have a Subacute Care Program contract with DHCS SCU. Facilities must submit an application to SCU by December 15, 2023. The list of the currently contracted providers is available on the Medi-Cal Subacute website. Facilities already contracted with DHCS SCU do not need to take any action.

		Facilities not contracted contact the DHCS' SCU to request an application. For more information, refer to the Medi-Cal Subacute Care Contracting: Application Information for Facilities Fact Sheet on the DHCS website. Additional information on the Subacute Care Facility Carve-In can also be found on the site.
Substance Use Disorder Preventive Services	Not covered by the Health Plan	Please bill the state for these services.
Temporomandibular Joint Disorder (TMJ) – Medical Treatment	Covered	
Tobacco Cessation	Covered	Some limitations apply. Only the following codes are payable at this time: 99406, 99407, G0436, and G0437. Age and diagnosis restrictions do apply. Please contact your California Health & Wellness Plan Provider Network Specialist for more information. For a complete listing of covered medications and associated restrictions, refer to the Medi-Cal Rx Contract Drug List (CDL)
Transplant Services (members under age 21)	Services are covered by California Children's Services (CCS)	For members under age 21, refer to CCS guidelines at the following link: Transplants.
Major Organ Transplants (MOT)	Covered for members ages 21 and over	All MOT requests must be submitted by the transplant center directly to the Centene Centralized Transplant Unit (CTU).

Urgent Care Center Services	Covered	
Vision - Other than Optical Lenses	Covered	Benefit managed by Envolve Vision Care visionbenefits.envolvehealth.com
Vision – Optical Lenses	Covered	Benefit managed by Envolve Vision Care visionbenefits.envolvehealth.com

Adverse Childhood Experiences (ACEs) Screening

The following information is intended to provide a general guide to help you implement screening for adverse childhood experiences (ACEs) and better determine the likelihood a patient is at increased health risk due to a toxic stress response. Screening for ACEs helps inform patient treatment and encourage the use of trauma-informed care. For more information, visit www.acesaware.org.

I. Prevent

Trauma Informed Care

ACEs are stressful or traumatic experiences people have by age 18, such as abuse, neglect and household dysfunction. By screening for ACEs, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response. This is a critical step in advancing to trauma-informed care.

Follow the principles of trauma-informed care. Use these key principles as a guideline:

- Establish the physical and emotional safety of patients and staff.
- Build trust between providers and patients.
- Recognize the signs and symptoms of trauma exposure on physical, psychological and behavioral health.
- Promote patient-centered, evidence-based care.
- Train leadership, providers and staff on trauma-informed care.
- Ensure provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed-upon goals for treatment.
- Provide care that is sensitive to the racial, ethnic, cultural and gender identity of patients.

References

For more information, refer to:
www.acesaware.org/treat/principles-of-trauma-informed-care/healthcaretoolbox.org/

Toxic Stress

Everyone experiences stress. Stress can show up in our bodies, emotions and behavior in many different ways. Too much of the wrong kind of stress can be unhealthy and, over time, become "toxic" stress and harm physical and mental health. An adult who has experienced significant adversity in the past, especially during the critical years of childhood, may be at higher risk of experiencing health and behavioral problems during times of stress.

References

For more information, refer to:
www.acesaware.org/treat/the-science-of-aces-toxic-stress/
covid19.ca.gov/manage-stress-for-health/
compassionfatigue.org/
healthychildren.org/English/Pages/default.aspx

II. Screen for ACEs

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

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

For children and adolescents, use PEARLS.

PEARLS is designed and licensed by the Center for Youth Wellness and are available in additional languages. There are three versions of the tool based on age:

- PEARLS for children ages 0–11, to be completed by a parent/caregiver.
- PEARLS for ages 12–19, to be completed by a parent/caregiver.
- PEARLS for teenagers ages 12–19, self-reported.

For adults, use the ACE assessment tool.

The ACE assessment tool is adapted from the work of Kaiser Permanente and the Centers for Disease Control and Prevention (CDC). Other versions of the ACEs questionnaires can be used, but to qualify, questions must contain the 10 categories mentioned above.

Use of tools

Ages	Use this Tool	To receive directed payment
0-17	PEARLS	Permitted for periodic ACE rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened

		periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1]
18 or 19	ACEs or PEARLS	Permitted for periodic ACE rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1]
20-64	ACEs screening portion of the PEARLS tool (Part 1) can also be used.	• **Age 20:** Permitted for periodic ACE rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology. • **Adults ages 21 through age 64:** Permitted once in their adult lifetime (through age 64), per clinician (per managed care plan). Screenings completed while the person is under age 21 do not count toward the one screening allowed in their adult lifetime. Adults should be screened at least once in adulthood, and though ACEs occur in childhood (by definition) and therefore do not change, patient comfort with disclosure may change over time, so re-screening for adults may be considered.[1]

[1]https://www.acesaware.org/learn-about-screening/billing-payment.

The approved tools are available in two formats:

- **De-identified screening tool:** Patients have the option to choose a de-identified screening, which counts the numbers of experiences from a list without specifying which adverse experience happened.
- **Identified screening tool:** Patients can opt in for an identified screening in which respondents specify the experience(s) that happened to their child or themselves.

Providers are encouraged to use the de-identified format to reduce the fear and anxiety patients may have.

Administering the screening

There are several ways to administer the screening. Providers are encouraged to use the tools appropriate for their patient population and clinical workflow. Before administering, providers should consider the following:

- Identify which screening tools and format to use for adults, caregivers of children and adolescents, and adolescents.
- Determine who should administer the tool, and how.
- Determine which patients should be screened.

It is recommended that the screening be conducted at the beginning of an appointment. Providers or office staff will provide an overview of the questionnaire and encourage the patients (adolescent, adults or caregivers) to complete the form themselves in a private space to allow members to disclose their ACEs without having to explain their answers. Patients may take up to five minutes to complete the screening tool.

References

For more information, refer to:
www.acesaware.org/screen/screening-tools/
www.acesaware.org/wp-content/uploads/2019/12/ACE-Clinical-Workflows-Algorithms-and-ACE-Associated-Health-Conditions.pdf

III. Treatment

The ACE score determines the total reported exposure to the 10 ACE categories indicated in the adult ACE assessment tool or the top box of the pediatric PEARLS tool. ACE scores range from 0 to 10 based on the number of adversities, protective factors and the level of negative experience(s) that have impacted the patient. Providers will obtain a sum total of the number of ACEs reported on the screening tool.

For children and adults, two toxic stress risk assessment algorithms based on the score were developed to determine the level of risk and referral needs. According to the algorithm, risk and scores are determined as follows:

Risk	Score	Action
Low	0	If a patient is at low risk, providers should offer education on the impact of ACEs, anticipatory guidance on ACEs, toxic stress and buffering factors.
Intermediate	1 – 3	A patient who scores 1–3 has disclosed at least one ACE-associated condition and should be offered educational resources.
High	1 – 3 with associated health conditions, or a score of 4 higher	The higher the score, the more likely the patient has experienced toxic stress during the first 18 years of life and has a greater chance of experiencing mental health conditions, such as depression, post-traumatic disorder, anxiety and engaging in risky behaviors.

References

For more information, refer to:
www.acesaware.org/treat/**Error! Hyperlink reference not valid.**
www.acesaware.org/heal/resources/

IV. Heal: Referral and Resources

As part of the clinical workflow, providers should be prepared with a treatment plan and referral process so patients who have identified behavioral, social or trauma can be connected to trained professionals and resources. Building a strong referral network and conducting warm hand-offs

to partners and services are vital to the treatment plan. In addition, it is critical to build a follow-up plan to effectively track the patient's process to ensure they get connected to the support needed.

ACEs resources

Free resources offered by ACEs for providers on screening and clinical response.

www.acesaware.org/heal/resources/

MHN

California Health & Wellness Plan (CHWP) Medi-Cal members can obtain individual and group mental health evaluation and treatment. Providers can contact MHN at 1-844-966-0298 or access the website at www.mhn.com/providers.html.

Case Management

If your patient is uncertain about next steps or would like to learn more, please refer them to the health plan's behavioral health case management at 1-877-658-0305.

Findhelp

Findhelp, formerly known as Aunt Bertha, is the largest online search and referral platform that provides results customized for the communities you and your health care staff serve or where members live. To use the tool:

1. Go to https://cahealthwellness.findhelp.com.
2. Enter a ZIP Code and click *Search*.

myStrength

For members with ACEs, the myStrength program can provide an additional resource. If a member needs emergent or routine treatment services, call MHN at 1-888-327-0010. To refer a member to the myStrength program, members can visit myStrength.com to sign up online or download the myStrength app at **Google Play** or the **Apple Store.** To join online:

1. In a web browser enter https://bh.myStrength.com/cahealthwellness.
2. Click *Sign Up* and complete the brief wellness assessment and personal profile.

Health Education Materials

For health education materials, providers can call the CHWP Health Education Information Line at 1-800-804-6074 (TTY: 711)

ACE Training and Self-Attestation Requirement for Billing

Effective July 1, 2020, Medi-Cal providers who have completed the two-hour online ACE training and submitted their self-attestation to DHCS can continue or begin billing for ACE screenings. Providers who missed the July 1 deadline can still complete the training, self-attest and begin billing the month of completing the attestation.

- **To get started,** register for the online training at training.acesaware.org.
- **To self-attest,** complete the Department of Health Care Services (DHCS) Trauma Screening Training Attestation form available at: www.medi-cal.ca.gov/TSTA/TSTAattest.aspx.

You must attest with a valid NPI number, or you will not be eligible to receive payment. Our support teams at Provider_Services@healthnet.com and HN_Provider_Relations@healthnet.com will have the latest DHCS Prop 56 **ACEs Provider Training Attestation List** and be able to look up the customer/provider to see if DHCS has received their ACEs training attestation online form.

Existing and future trainings on ACEs
ACEs Aware offers a variety of trainings on ACEs and Trauma Informed Care. To access and view existing trainings or register for future trainings to support your work with ACEs, visit the ACE Aware site acesaware.org.

Non-Emergent Medical Transportation and Non-Medical Transportation

California Health & Wellness Plan arranges for the non-emergent transportation and non-medical transportation of members for medically necessary services, which include carve-out services, if requested by the member or someone on behalf of the member. A Physician Certification Statement form is required for NEMT services. **To arrange for non-emergent medical transportation or non-medical transportation for a California Health & Wellness Plan member, the provider should call our Member Services department at 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 877-658-0305 number)**. California Health & Wellness Plan requires the transportation provider to schedule transportation so that the member arrives on time but no sooner than one hour before the appointment, does not have to wait more than one hour after the conclusion of the treatment for transportation home, and not have to leave prior to completion of treatment. California Health & Wellness Plan requests its participating providers, including its transportation vendor, inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

Network Development and Maintenance

California Health & Wellness Plan facilitates the provision of covered services as specified by Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the DHCS and DMHC network adequacy requirements for the Managed Care Organization networks. California Health & Wellness Plan maintains a network of qualified providers in sufficient numbers, geographic distribution and specialty coverage to meet the medical needs of its members. This includes consideration of the needs of adults and children, as well as members' travel requirements, so that our network complies with DHCS and DMHC access and availability requirements.

California Health & Wellness Plan offers a network of Primary Care Providers (PCP) to provide each member with access to primary care within the required travel distance standards. Providers

who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistant and advanced registered nurse practitioners.

In addition, the following specialists are available on referral basis:

- Allergy
- Dermatology
- Cardiology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Pulmonary Disease
- Rheumatology
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Optometry
- Orthopedics
- Otolaryngology
- Pediatric (Subspecialties)
- Cardiology
- Hematology/Oncology
- Physical Medicine and Rehabilitation
- Podiatry
- Surgery (General)
- Urology
- Vision Care/Primary Eye Care
- Psychiatry/Psychology
- Marriage and Family Therapists
- Licensed Clinical Social Workers

In the event California Health & Wellness Plan's network is unable to provide medically necessary services required under the contract, California Health & Wellness Plan facilitates timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted, and coordinates authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a California Health & Wellness Plan member, please contact our Medical Management team at

(877) 658-0305 **(For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)** and we will identify a provider to make the necessary referral.

Tertiary Care

California Health & Wellness Plan offers a network of tertiary care inclusive of level one and level two trauma centers, neonatal intensive care units, perinatology services, comprehensive cancer services, comprehensive cardiac services and pediatric sub-specialists available 24-hours per day. In the event California Health & Wellness Plan network is unable to provide the necessary tertiary care services required, California Health & Wellness Plan facilitates timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted. California Health & Wellness Plan coordinates authorization and payment issues in these circumstances.

CHAPTER 5: PHARMACY PROGRAM

California Health & Wellness Plan covers prescription medications and certain over-the-counter (OTC) medications when prescribed by a licensed provider under the Medi-Cal Rx program. The Medi-Cal Rx pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities.

Contract Drug List (CDL)

What is the CDL?

The Medi-Cal Rx CDL is the list of covered drugs that the Medi-Cal Rx program covers. The Medi-Cal Rx CDL applies to drugs that members can receive at retail pharmacies. The purpose of the CDL is to provide member access to quality, cost-effective medications on a timely basis.

How to Access the CDL

Providers can access the most current Medi-Cal Rx CDL at https://medi-calrx.dhcs.ca.gov/home or by visiting the California Health & Wellness Plan website http://www.cahealthwellness.com. From the home page, click on the "For Providers" tab and select "Pharmacy" from the drop down menu. The CDL is available via the "Contract Drug List (CDL)" link in the middle of the page.

Questions regarding coverage and requirements of the prescription drug benefit

Questions regarding the below coverage and requirements of the prescription drug benefit should be directed the Medi-Cal Rx program.

- Dispensing Limits
- Generic Drugs
- Over-the-Counter Medications
- Smoking Cessation Drugs
- Continuation of Care for Transitioning and New Members
- Exclusions

Enteral Nutrition Products

California Health & Wellness Plan and Medi-Cal Rx cover enteral nutrition products under the following conditions:

- Home Infusion: Submit prior authorizations for pumps and associated supplies needed for enteral nutrition to California Health & Wellness DME Department at 866-724-5057. Billing must be through California Health & Wellness Plan Medical Billing.

- Bolus/Gravity/Oral: Submit Prior Authorizations to Medi-Cal Rx at 800-869-4325. Billing must be handled through a Medi-Ca Rx network pharmacy using pharmacy claims.
- If the member is under 21 years old, CCS eligibility is verified.

"Carve Out" Drugs Covered by the Medi-Cal Rx Program

Certain drugs and physician-administered drugs are not covered by California Health & Wellness Plan, but instead are covered by the Medi-Cal Rx. All authorization requests and claims for the specific drugs listed in the Medi-Cal Provider Manual are submitted directly to Medi-Cal Rx. These drugs include:

- Select HIV AIDS treatment drugs
- Select alcohol and heroin detoxification and dependency treatment drugs (e.g., Campral®, Suboxone®)
- Select psychiatric drugs (e.g., Abilify®, Risperdal®)
- Select coagulation factors

California Children's Services (CCS) Carve-Outs

Drugs prescribed for CCS-approved conditions by a CCS-paneled provider are covered by the CCS program and not California Health & Wellness Plan. All authorization requests and claims must be submitted directly to the CCS program.

Requesting Prior Authorization (PA) for Medications

Some medications listed on the Medi-Cal Rx Contract Drug List (CDL) may require prior authorization.

How to Request a Medication Prior Authorization

California Health & Wellness Plan works with **Medi-Cal Rx** to process all pharmacy claims for prescribed drugs. Medi-Cal Rx is responsible for processing and administering the medication prior authorizations process for all self-administered drugs requiring prior authorization. To submit a medication prior authorization request, follow these guidelines:

1. Submit a state-mandated prior authorization form:
    a. *By Fax*: Complete the prior authorization request form, which can be found on the Manuals, Forms and Resources page of the California Health & Wellness Plan website, and fax the request to Medi-Cal Rx at **800-869-4325.**

    b. *Online*: A prior authorization form can be completed and submitted electronically to Medi-Cal Rx using CoverMyMeds®.

Medications Requiring a Prior Authorization

Some medications require prior authorization from Medi-Cal Rx. These include the following:

- Medications not listed on the Medical Rx Contract Drug List (CDL).

- Medications that are listed on the Medi-Cal Rx CDL and specifically require prior authorization.
- Medications that are on the Medi-Cal Rx CDL with restrictions or limitations and the member has not satisfied the required restrictions or limitations.

Contact Medi-Cal Rx at 800-977-2273 with any questions regarding prior authorization.

Filing an Appeal of a Medication Adverse Determination

A provider or member can contact Medi-Cal Rx to file an appeal for pharmacy benefit medication denials. However, Medi-Cal Rx is not responsible for appeals. Appeals for Medi-Cal Rx prior authorization denial is handled through the State Fair Hearing process by calling: **800-743-8525**. **TDD users, call 800-952-8349**. Information about requesting a hearing can be obtained on the DHCS website at www.dhcs.ca.gov by selecting *Services > All Programs and Services > Fair Hearing*.

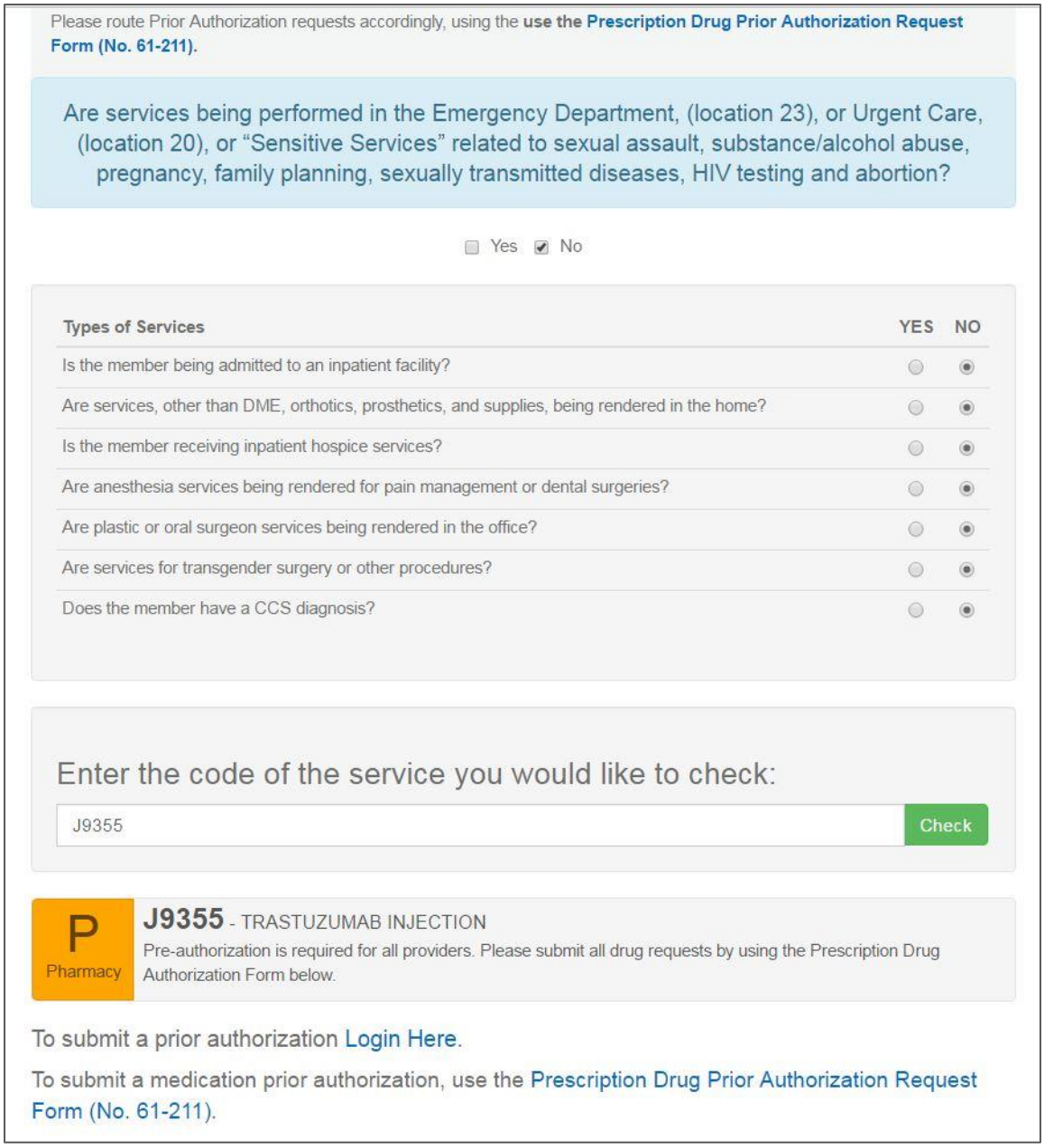
You can also **MAIL** this State Hearing Request to:

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

Physician-Administered Medication Requests

California Health & Wellness Plan Pharmacy Department is responsible for reviewing all physician-administered medication requests. Select physician-administered medications require prior authorization to be approved for payment. Providers can determine whether prior authorization is required by entering the HCPS code into the "Pre-Auth Check" tool located at www.CAHealthWellness.com.

- Follow the steps below to locate the "Pre-Auth Check" tool, or click on this link (Pre-Auth Check).
  - Go to www.CAHealthWellness.com
  - Under "For Providers", click on the "Pre-Auth Needed?" tool
  - Select the Health Plan
  - Answer the questions
  - After answering all of the questions a search option will appear
  - Enter the HCPS code
  - A message will come up showing if the HCPS code requires a prior authorization



- If a prior authorization is required, please follow the steps below.
  - For members under 21 years of age, check for CCS coverage
  - Complete the state-mandated Prescription Drug Prior Authorization Request Form (No. 61-211)
  - Submit a completed form by fax to California Health & Wellness Plan at **(877) 259-6961**
  - If approved, the prescriber is notified by fax
    - If needed, California Health & Wellness Plan can coordinate the provision of approved medications to the provider for administration
  - If the clinical information provided does not meet the coverage criteria for the requested medication, the member and the prescriber are notified of the reason for

denial, listing any alternatives if appropriate, and are provided information regarding the appeal process

- If a prior authorization is not required, please submit the claim
    - The medication might not require a prior authorization; however, the services or non-participating provider might require authorization

Provision of Specialty Pharmacy for Physician-Administered Drugs

AcariaHealth is the provider of specialty medications for California Health & Wellness Plan. Most specialty medications require prior authorization to be approved for payment. Providers can request that AcariaHealth deliver the specialty drug to the provider's office or to the member. Follow these guidelines for the most efficient processing of your specialty medication prior authorization requests.

- Complete the state-mandated Prescription Drug Prior Authorization Request Form
- Submit a completed form by fax to California Health & Wellness Plan at **(877) 259-6961.** If approved, the prescriber is notified by fax and arrangements are made for the provision of the medication.
    - Fax prescription to AcariaHealth at **(855) 217-0926**
    - AcariaHealth can be reached at **(855) 535-1815**

If the clinical information provided does not meet the coverage criteria for the requested medication, the member and the prescriber are notified of the reason for denial, listing any alternatives if appropriate, and are provided information regarding the appeal process.

Drug Utilization Review (DUR) Program

California Health & Wellness Plan utilizes retrospective DUR programs using standards, criteria, protocols, and procedures approved by the California Health & Wellness Plan Pharmacy & Therapeutics (P&T) Committee in accordance with applicable state and federal requirements and NCQA standards.

- The DUR program alerts prescribers and/or dispensing pharmacists by identifying overuse, underuse, inappropriate or medically unnecessary care, and to address safety concerns associated with specific drugs, including potential for drug interactions.
- The DUR program also functions to identify opportunities to improve the quality of care for patients including adherence to prescribed therapy and improvements in the medication regimen consistent with the patient's diagnoses or conditions.

Drug Utilization Review Requirements

California Health & Wellness Plan and entities delegated to review prescriptions filled by the Medi-Cal Rx program ("applicable entities") must:

- Operate a drug utilization review (DUR) program[1]
- Submit the following to the Department of Health Care Services (DHCS):

- Updated policies and procedures that address each of the requirements detailed below.
- Annual DUR Report.

Requirements for the DUR program

The requirements include but not limited to the topics listed below.

- Safety edits, including early, duplicate and quantity limits
- Maximum daily morphine milligram equivalents (MME) safety edits
- Concurrent utilization alerts
- Permitted exclusions to utilization management restrictions

Monitoring of antipsychotic medications used by children

Managed care plans (and applicable entities) are required to have a process to monitor and manage appropriate use of all psychiatric drugs to include antipsychotics, mood stabilizers and anti-depressant medications for all children under age 18 and all foster children. Based on the DUR program monitoring findings, the DUR program must have a process to address and improve concerning findings.

Identification of fraud, waste and abuse

Describe the process for identifying and addressing fraud and abuse of controlled substances by members, health care providers who are prescribing drugs to members, and pharmacies dispensing drugs to members. Also describe the actions that will be taken based on issues identified through program-monitoring findings.

[1]The DUR program must comply with Medicaid-related DUR provisions contained in section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R. 6, the SUPPORT Act, P.L. 115-271).

CHAPTER 6: STATE AND COUNTY PROGRAMS

There are some health care services that California Health & Wellness Plan members can receive as Medi-Cal beneficiaries, although these services are not covered by California Health & Wellness Plan specifically. They may be covered by California Children's Services (CCS), another state or federal program, or local county agency. It is important to note that some of these services may also have special eligibility requirements, and not all members may qualify for these services.

If a patient is a California Health & Wellness Plan member who needs services that are covered by the Medi-Cal Fee-for-Service program and not by California Health & Wellness Plan, the member should understand that he/she must: (1) be eligible to receive these services and (2) find a Medi-Cal provider who offers these services. If a member is eligible for these services, please remind the member to take his/her Medi-Cal card when he/she visits that provider.

For more information about Medi-Cal benefits not covered by California Health & Wellness Plan, call Provider Services at 1-877-658-0305. For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number. Services administered by Medi-Cal Fee-for-Service or other state or county agencies that California Health & Wellness Plan members may qualify for include:

- **Acupuncture Services --** The Medi-Cal Fee-For-Service program covers acupuncture services and they are not covered by California Health & Wellness Plan. For more information, please use this link (Acupuncture) and then scroll down and click on the link for "Acupuncture Services."

- **Acute Detoxification Services, including Voluntary Inpatient Detoxification, Heroin Detoxification, Substance Abuse Services** - The member's PCP will decide if the member needs any treatment service. If so, the member's PCP should refer the member to the substance abuse treatment program that is run by the Medi-Cal Drug Treatment Program. These services are not covered by California Health & Wellness Plan and should be billed to the State. We will assist with coordination of services as needed. California Health & Wellness Plan members can receive these services without having to disenroll from California Health & Wellness Plan.

- **California Children's Services (CCS)** - California Children Services (CCS) covers eligible services for members under age 21. These services are condition specific. CCS services are not covered under the California Health & Wellness Plan. These services must be rendered by CCS paneled providers and/or facilities.

  Plan members are eligible to enroll in (or continue enrollment in) California Children's Services (CCS). This includes children from birth up to age 21 with CCS-eligible medical conditions. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical

conditions (such as hemophilia, cerebral palsy, heart disease, cancer, infectious diseases producing major sequelae). The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS).

A provider should refer the child to CCS if the provider has sufficient clinical detail to establish, or raise a reasonable suspicion, that the child has a CCS-eligible medical condition. California Health & Wellness Plan coordinates with the member, provider and CCS as needed to facilitate the referral. CCS pays for CCS approved services that are associated with an eligible diagnosis. CCS only reimburses for services rendered by CCS-paneled providers and approved by CCS. California Health & Wellness Plan does not pay for services that are covered by CCS.

California Health & Wellness Plan provides all medically necessary covered services that are not authorized by CCS and coordinates services and joint case management between the provider, the CCS specialty providers, and the local CCS program.

To learn about CCS, become a CCS provider, refer a member to CCS, check eligibility or view a county contact list, please use the following link for the DHCS CCS program website: CCS.

- **California Children's Services Eligible Services for Life-Limiting Conditions -** Hospice care options for children do not fit the traditional adult hospice model. Effective January 1, 2019, pediatric palliative care will be authorized and managed by the health plan through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for members who meet the eligibility criteria.

  Policy guidelines and directions for authorization of medically necessary services related to a CCS life-limiting condition for children who have elected hospice is available on the DHCS website at: www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf.

  California Health & Wellness Plan (CHWP) and its delegated independent practice association (IPA) work with CCS to help with continuity of medical care. This includes keeping the current relationship between patient and provider. If elected, hospice care for children with terminal diseases requires working closely with CHWP, the IPA, the local CCS program, and other caregivers. Hospice counseling, including grief, bereavement and spiritual services, may be needed during this transition.

- **Concurrent Hospice, Palliative and Curative Care for Children** A member under age 21 may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302 as detailed in CMS Letter #10-018. Information regarding the concurrent care policy is available in Policy Letter (PL) 11-004, titled "The Implementation of Section 2302 of the Affordable Care Act, titled "Concurrent Care for Children"; APL 13-014; and the appropriate

California Children's Services (CCS) Numbered Letter (NL), including any future iterations of these letters.

Palliative care Options for CCS Eligible Children N.L. 12-119 provides additional palliative care information on the DHCS website at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1119.pdf.

Note: Palliative care services may be authorized by CCS if they are part of a plan of care of a CCS special care center (SCC). CCS is financially responsible for the palliative care services and not the health plan.

- **Childhood Lead Poisoning Case Management Services -** These services are provided by the Public Health Department in the county in which the member lives. For more information, contact:

  California Department of Public Health

  P.O. Box 997377, MS 0500
  Sacramento, CA 95899-7377
  Phone: (916) 558-1784
  MCI from TTY (800) 735-2929 or MCI from voice telephone (800) 735-2922
  Sprint from TTY (888) 877-5378 or Sprint from voice telephone (888) 877-5379

- **Dental Services -** California Health & Wellness Plan covers some medical services that support dental procedures. However, if a California Health & Wellness Plan member needs dental care, the member's PCP should refer him/her to a Denti-Cal dental provider. California Health & Wellness Plan members can also call the Denti-Cal Beneficiary Telephone Service Center at (800) 322-6384. Please visit www.dental.dhcs.ca.gov/.

- **Directly Observed Therapy for Tuberculosis** - If a California Health & Wellness Plan member has tuberculosis and requires Direct Observed Therapy (DOT), the member should be referred to the DOT Program run by the Public Health Department in the county in which the member lives. For more information, contact:

  California Department of Public Health

  P.O. Box 997377, MS 0500
  Sacramento, CA 95899-7377
  Phone: (916) 558-1784
  MCI from TTY (800) 735-2929 or MCI from voice telephone (800) 735-2922
  Sprint from TTY (888) 877-5378 or Sprint from voice telephone (888) 877-5379

- **Local Education Agency Assessment Services -** Local Education Agency (LEA) assessment and services are covered under Fee-For-Service Medi-Cal. Please visit www.dhcs.ca.gov/provgovpart/pages/lea.aspx.

- **Medications for HIV/AIDS, Substance Abuse/Detox, Select Coagulation Factors, and Certain Psychiatric Conditions -** Most prescription medications used to treat HIV/AIDS, substance abuse/detoxification, select coagulation factors, and certain psychiatric conditions are covered under the Medi-Cal Fee-for-Service program, subject to limitations.
- **Prayer or Spiritual Healing -** These services may be covered under the Medi-Cal Fee-for-Service program, subject to limitations.
- **Regional Centers** - Regional Centers provide services for people with intellectual or developmental disabilities, whose disability begins before the member's 18th birthday, is expected to continue indefinitely and presents a substantial disability. The Regional Center determines program eligibility based on a diagnosis and assessment performed by a Regional Center office. Six Regional Centers service the 19 counties in California Health & Wellness Plan's service area.

Regional Center	Website	California Health & Wellness Plan Counties Served
Alta California	http://www.altaregional.org	Alpine, Colusa, El Dorado, Nevada, Placer, Sierra, Sutter, Yuba
Far Northern	https://www.farnorthernrc.org	Butte, Glenn, Plumas, Tehama
Valley Mountain	http://www.vmrc.net	Amador, Calaveras, Tuolumne
Central Valley	http://www.cvrc.org	Mariposa
San Diego	http://sdrc.org	Imperial
Kern	http://www.kernrc.org	Inyo, Mono

To refer a member for eligibility determination, questions or additional information, please visit the Regional Center website at: www.dds.ca.gov/RC/RCSvs.cfm.

- **Serum Alpha Fetoprotein Testing Laboratory Services** - These services are provided under the state program administered by the Genetic Disease Branch of DHCS.

- **Fetal chromosomal aneuploidy genomic sequence analysis panel**, circulating cell-free fetal DNA in maternal blood, (trisomy 13, 18, and 21).

- **Fetal aneuploidy (trisomy 13, 18, and 21)**, DNA sequence analysis of selected regions using maternal plasma.

- **Skilled Nursing Facility or Intermediate Care Facility** - California Health & Wellness Plan covers medically necessary admissions to a skilled nursing facility or intermediate care facility.

- **Specialty Mental Health** - California Health & Wellness Plan members requiring specialty mental health services that are outside the scope of their PCP or outpatient Mental Health Services Provider (i.e. more intensive treatment needs including inpatient care), should be referred to the County Mental Health Plan in the county in which they live. While these services are not covered by California Health & Wellness Plan, members can receive these services with or without a referral from their doctor, and without having to disenroll from California Health & Wellness Plan. Members can receive these services with or without a referral from their doctor, and without having to disenroll from California Health & Wellness Plan.

  Please instruct California Health & Wellness Plan members who are in need of specialty mental health services to contact their PCP or California Health & Wellness Plan Member Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). We will help refer the member to a Mental Health Services Provider or the County Mental Health Plan in the county in which they live.

- **Waiver Program Services** - If a California Health & Wellness Plan member is accepted by Home and Community Based Services, AIDS Waiver Services or Senior Services program, he/she will receive waiver services through those programs. The member will also remain enrolled in California Health & Wellness Plan for his/her medical services.

CHAPTER 7: UTILIZATION MANAGEMENT

Contact Information for Medical Management Department

Please note that in this Chapter, we use the terms "Utilization Management" and "Medical Management" interchangeably, though Medical Management is generally inclusive of Utilization Management functions. For more information about our Medical Management program, providers can contact California Health & Wellness Plan's Medical Management Department as indicated below:

Medical Management

Phone: 1-877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
www.cahealthwellness.com

- California Health & Wellness Plan's Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m. (excluding holidays).
- After normal business hours, our 24-Hour Nurse Advice Line is available to answer questions about prior authorization.
- Medical Management services include the areas of utilization management, case management and disease management.
- The California Health & Wellness Plan Chief Medical Officer ("Medical Director") oversees the Medical Management Departments clinical services. The Vice President of Utilization Management has responsibility for direct supervision and operation of the department. To reach the Chief Medical Officer or Vice President of Utilization Management, please use the contact information provided above.

Utilization Management Program Overview

The California Health & Wellness Plan Utilization Management Program (UMP) is designed to facilitate our members' ability to access the right care, at the right place, at the right time. The UMP is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

California Health & Wellness Plan's UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Preventing the over- or under-utilization of services by monitoring utilization patterns
- Identifying and providing case and/or disease management for members at risk for significant health expenses or ongoing care
- Developing an infrastructure so that all California Health & Wellness Plan members establish relationships with their PCPs to obtain preventive care
- Implementing programs that encourage preventive services and chronic condition self-management
- Identifying members who may be eligible for other programs such as California Children's Services (CCS)
- Creating partnerships with members/providers to enhance cooperation and support for UMP goals

California Health & Wellness Plan's UMP provides the following service reviews:

- Prior Authorization
- Concurrent Review and Discharge Planning
- Retrospective Reviews
- Continuity of Care

California Health & Wellness Plan medical management staff makes decisions based upon medical evidence and clinical guidelines. Our staff is not compensated based upon the results of clinical decisions or outcomes. All medical management staff, including UMP staff, is required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.

Prior Authorization and Notifications

Overview and Key Points about Prior Authorization

Prior authorization is a request to the California Health & Wellness Plan Utilization Management (UM) department for approval of services before the service is delivered. Prior authorization helps make certain that a requested service is a covered benefit, based on medical necessity, and is provided by an appropriate provider. Some services require prior authorization from

California Health & Wellness Plan in order for reimbursement to be issued to the provider. Please note these important key points:

- **Authorization is not required for the following services:**
  - Urgent Care
  - Sensitive services related to sexual assault, substance/alcohol abuse, pregnancy, family planning, sexually transmitted diseases, HIV testing and abortion.
  - Emergency room and post-stabilization services. **Providers must notify California Health & Wellness Plan of emergent inpatient admissions within one business day of the admission for ongoing concurrent review and discharge planning**.
  - Sensitive services, including family planning and sensitive services for both women and men (for additional information contained in this Manual, use the following link: sensitive services).
- Authorization must be obtained prior to the delivery of certain elective and scheduled services.
- All inpatient admissions require notification within one business day. Clinical information may be required for ongoing care authorization of the service.
- Newborn admissions require notification within one business day for an additional authorization.
- Observation stays require notification within one business day of service.

Failure to obtain authorization may result in administrative claim denials. California Health & Wellness Plan providers are contractually prohibited from holding any member financially liable for any service administratively denied by California Health & Wellness Plan for failure of the provider to obtain timely authorization.

To verify whether a prior authorization is necessary or to obtain a prior authorization, visit our website or call:

California Health & Wellness Plan
Phone: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
www.cahealthwellness.com

Prior Authorization requests may be submitted electronically through the secure Provider Portal at www.cahealthwellness.com.

How to Determine Whether Prior Authorization is Required

Providers are responsible for verifying eligibility and ensuring that the California Health & Wellness Plan UMP has conducted pre-service reviews for certain elective non-emergency and

scheduled services before rendering those services. To determine whether prior authorization is required for a particular service, a provider may:

- Visit www.cahealthwellness.com and use the "Pre Auth Needed?" Tool (instructions on how to access the tool online are provided below); or
- Contact the prior authorization department for assistance at (877) 658-0305.

The table below reflects those services that require prior authorization. **Please note this list is not all-inclusive**. Please visit www.cahealthwellness.com and use the "Pre Auth Needed?" Tool or contact the prior authorization department for more information.

Summary of Services Requiring Prior Authorization

Services Requiring Prior Authorization	Notes
All inpatient hospitalizations	Notification at least 5 business days prior to the scheduled date of admit All hospitalizations to nonparticipating hospital once emergency stabilization is complete
All services other than well visits, preventive services, immunizations, emergency services, urgent care services, minor consent services (sexual assault, pregnancy care, family planning, sexually transmitted disease services), HIV testing, abortion	For members under age 21
Ablative techniques for treating Barrett's esophagus, and for treatment of primary and metastatic liver malignancies	
Bariatric surgery	
Bronchial thermoplasty	
Capsule endoscopy	
Cochlear implants	
Community Based Adult Services (CBAS)	Prior authorization is required for greater than 5 visits per week CBAS services with 1-5 visits per week require notification only Fax authorization and notifications to 1-855-556-7909

Durable medical equipment (DME) - including but not limited to: • Bilevel positive airway pressure (BiPAP) or continuous positive airway pressure (CPAP) • Bone growth stimulator • Custom-made items including orthotics • Hospital beds and mattresses • Items with a total Medi-Cal purchase price greater than $1,500 • Oxygen • Power wheelchairs or scooters • Prosthetics • Ventilators	All DME for pediatric members requires prior authorization Certain procedure codes; call or go to CHW website to determine if authorization is required
Emergency admissions (notification within 1 business day of admission)	
Enteral nutrition products	
Experimental or investigational treatments/services; clinical trials	
General anesthesia for dental services	
Hospice	Inpatient hospice
Intensive cardiac rehabilitation (ICR) services – outpatient	ICR services must be provided within an ICR program approved by the Centers for Medicare & Medicaid Services (CMS). Providers must include the following information when submitting a prior authorization request for ICR services: • CMS-approved program the member is participating in • Qualifying diagnosis • Treatment plan • Duration of services
Joint surgeries	
Laboratory services: • Genetic/molecular diagnostic testing • Quantitative drug screening	
Long-term care nursing facility admissions	Fax referral form to 866-724-5057
Lung volume reduction	
Maze procedures	
Mental health	Services such as psychological testing and neuro-psychological testing for individuals with mild to moderate treatment needs require prior authorization. Following a PCP's EPSDT screening, behavioral health treatment for members require prior authorization.
Nursing facility admissions (skilled nursing facility)	
Orthognathic procedures (includes TMJ treatment)	

Out-of-network providers and services	Services rendered by out-of-network providers require prior authorization. Excludes emergency services and self-referral services allowed under the Medi-Cal plan for family planning, pregnancy termination, HIV counseling and testing, immunizations at the local health department, and sexually transmitted infections (STIs).
Outpatient surgeries and procedures performed in outpatient facilities or ambulatory surgery centers	Certain procedure codes; call or go to CHWP website to determine if authorization is required
Outpatient therapies: physical, occupational and speech	Requires prior authorization **after** 12 combined visits. Includes home setting.
Pain management services	
Pharmacy services	See the CDL link on CHWP website for list of drugs covered by the Medi-Cal Rx program.
Radiology imaging-CT, MRA, MRI, PET	Go to www.radmd.com
Reconstructive and cosmetic surgery, services and supplies, including, but not limited to: • Bone alteration or reshaping, such as osteoplasty • Breast reduction and augmentation except when following a mastectomy (includes for gynecomastia or macromastia) • Dermatology, such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants • Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas. • Eye or brow procedures, such as blepharoplasty, brow ptosis or canthoplasty • Muscle flap • Nasal surgery such as rhinoplasty or septoplasty • Otoplasty • Penile Implant • Treatment of varicose veins	
Rehabilitation - Inpatient	
Specialist consultation and/or procedures	For members under age 21
Specialty and bio-pharmaceutical therapy	See CHWP Provider Website “Pharmacy” page for Specialty Pharmacy PA Information and “Pre-Auth Check” page for checking PA status of provider administered drugs.

Spinal surgery, includes, but not limited to, laminotomy, discectomy, vertebroplasty, nucleoplasty, and X-stop	
Transplant services including evaluation: All transplant services for Medi-Cal members under age 21 are coordinated through California Children's Services (CCS). Medi-Cal members under age 21 with CCS-eligible conditions who require transplant must be referred to CCS. All major organ transplant (MOT) requests (evaluation and listing) for members aged 21 or over must be submitted by the transplant center directly to the Centene Centralized Transplant Unit (CTU) through the provider portal or via fax. CAR-T cell therapy, corneal transplant, tissue transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy requests for members aged 21 or over must be submitted directly to CHWP.	**MOT requests**: Use the provider portal or fax requests directly to the CTU at 833-769-1140. **All other transplant requests:** Use the provider portal or fax requests to 866-724-5057.
Transportation	All non-emergency medical transportation (NEMT) require a Physician Certification Statement (PCS) (PDF). Fax form to 877-457-3352. • Air transportation (air ambulance), authorized by **California Health and Wellness** • Ground NEMT, contact **Modivcare** (ambulance, gurney/stretcher, wheelchair)
Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP	
Ventriculectomy, cardiomyoplasty	
Vestibuloplasty	
Wound care	Includes but not limited to: • Negative pressure wound treatment, low-frequency ultrasound • Skin substitutes and biologicals • Wound debridement – authorization required after 12 sessions per year

NON-BENEFIT SERVICES	PRIOR AUTHORIZATION – CALIFORNIA
COMMUNITY SUPPORTS • Asthma remediation • Community transition services • Day habilitation • Environmental accessibility adaptations (home modifications) • Housing deposits	Refer to the CalAIM Resources for Providers page.

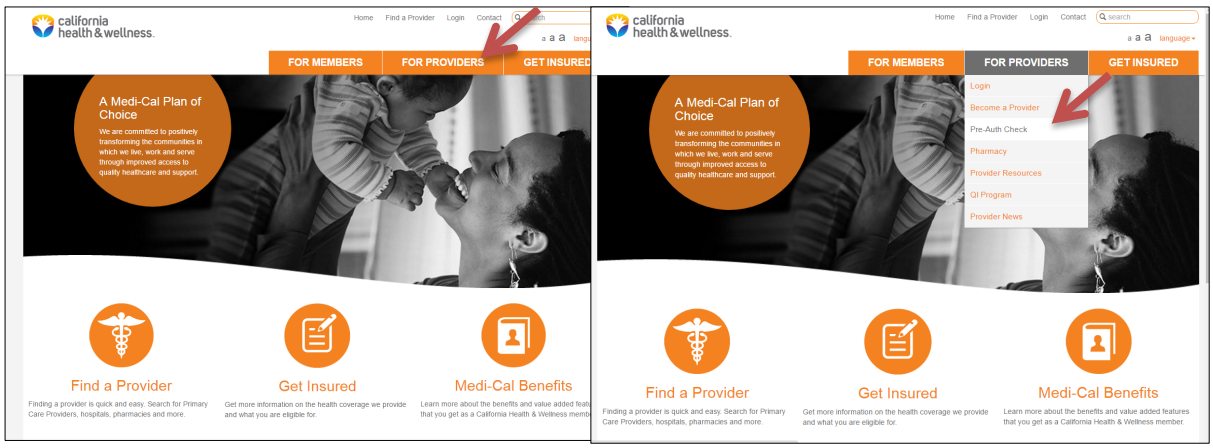
• Housing tenancy and sustaining services • Housing transition navigation services • Meals/medically tailored meals • Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for elderly and adult residential facilities • Personal care and homemaker services • Recuperative care (medical respite) • Respite services • Short-term post-hospitalization housing • Sobering centers	

Please also note that most out-of-network services require prior authorization and will require California Health & Wellness Plan Medical Director review and approval.

How to Check Online Whether Prior Authorization is Needed

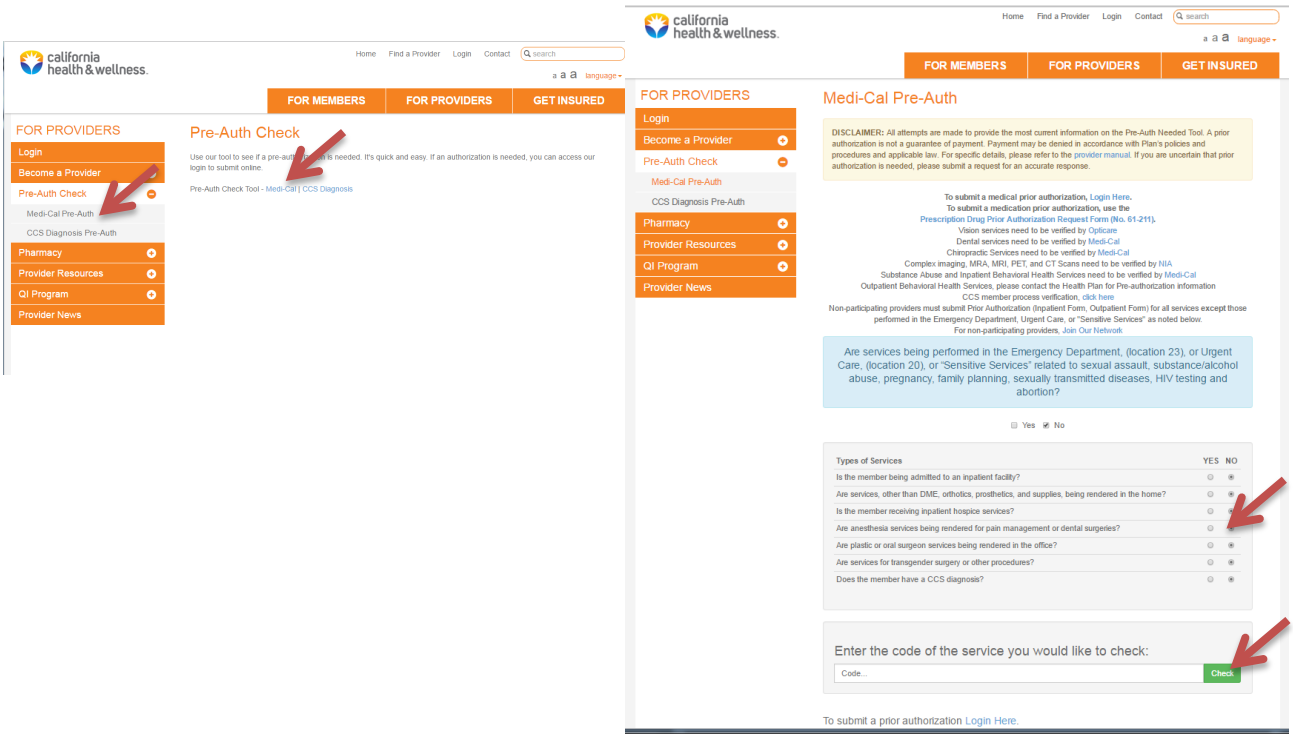
Providers can check if a prior authorization is required for specific codes by using the California Health & Wellness Plan website.

Step 1: Navigate to www.cahealthwellness.com and click on the "For Providers" dropdown menu. Then click "Pre-Auth Check."



Step 2: Select Medi-Cal or Medi-Cal Pre-Auth link.

Step 3: Answer the questions on the screen.



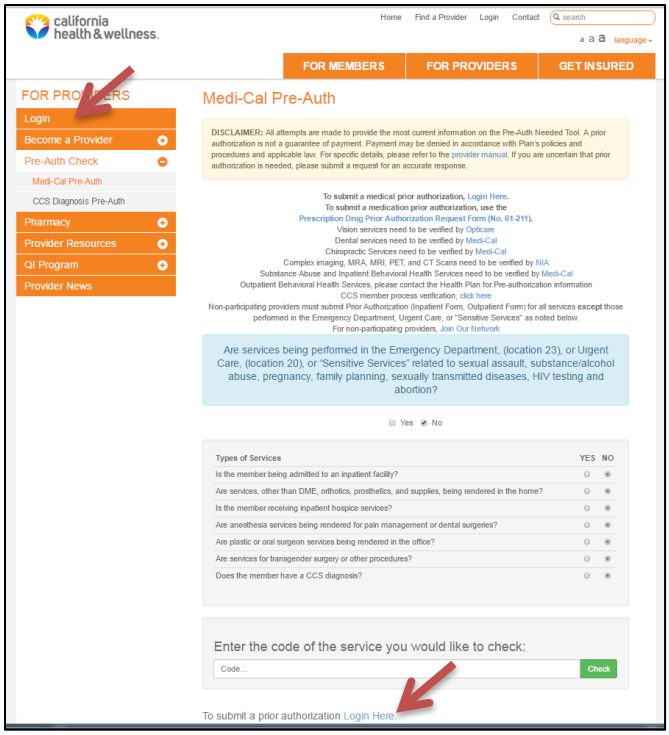
After completing answers to the on-screen questions, the website will either display a message indicating an authorization is required, or the code checker box will be displayed. When the code checker box is displayed, enter the specific code for the service to be rendered, and click on "Check." A message will be displayed indicating whether or not an authorization is required for that specific code.

How to Submit a Prior Authorization Online or by Fax

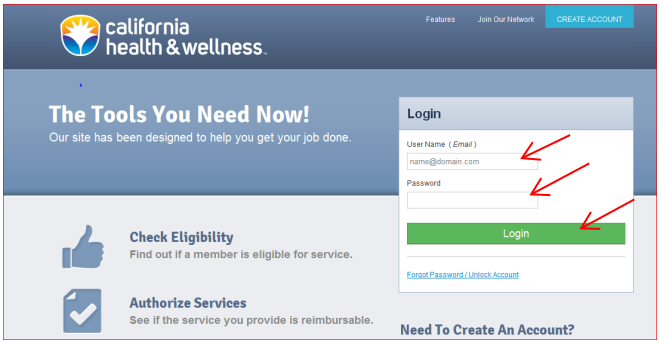
Requests for prior authorization can be submitted online or by fax. The PCP should contact the UM Department via fax or through our website with appropriate supporting clinical information to request an authorization.

Online Submission of a Prior Authorization Request – Providers are able to submit authorization requests online by logging on to a secure Provider Portal at www.cahealthwellness.com.

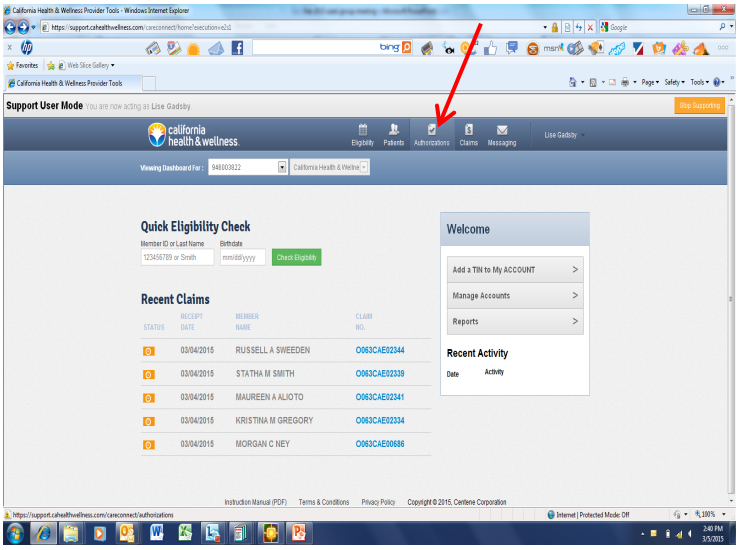
***Step 1*:** To submit an electronic request, login to the California Health & Wellness Plan's secure Provider Portal by clicking on the following link: login screen. Alternatively, providers can also follow the instructions above to access the "Medi-Cal Pre-Auth" page. Once on the "Medi-Cal Pre-Auth" page, sign into the secure Portal by clicking on "Login" on the left navigation bar or "Login here" link under the Code Checker box. This will take the provider to California Health & Wellness Plan's secure Provider Portal (see screenshot below).


california health & wellness.
Home
Find a Provider
Login
Contact
search
language
FOR MEMBERS
FOR PROVIDERS
GET INSURED
FOR PROVIDERS
Login
Become a Provider
Pre-Auth Check
Medi-Cal Pre-Auth
CCS Diagnosis Pre-Auth
Pharmacy
Provider Resources
QI Program
Provider News
Medi-Cal Pre-Auth
DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. A prior authorization is not a guarantee of payment. Payment may be denied in accordance with Plan's policies and procedures and applicable law. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.
To submit a medical prior authorization, Login Here.
To submit a medication prior authorization, use the
Prescription Drug Prior Authorization Request Form (No. 61-211).
Vision services need to be verified by Opticare
Dental services need to be verified by Medi-Cal
Chiropractic Services need to be verified by Medi-Cal
Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by NIA
Substance Abuse and Inpatient Behavioral Health Services need to be verified by Medi-Cal
Outpatient Behavioral Health Services, please contact the Health Plan for Pre-authorization information
CCS member process verification, click here
Non-participating providers must submit Prior Authorization (Inpatient Form, Outpatient Form) for all services except those performed in the Emergency Department, Urgent Care, or "Sensitive Services" as noted below.
For non-participating providers, Join Our Network
Are services being performed in the Emergency Department, (location 23), or Urgent Care, (location 20), or "Sensitive Services" related to sexual assault, substance/alcohol abuse, pregnancy, family planning, sexually transmitted diseases, HIV testing and abortion?
Yes
No
Types of Services
YES
NO
Is the member being admitted to an inpatient facility?
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?
Is the member receiving inpatient hospice services?
Are anesthesia services being rendered for pain management or dental surgeries?
Are plastic or oral surgeon services being rendered in the office?
Are services for transgender surgery or other procedures?
Does the member have a CCS diagnosis?
Enter the code of the service you would like to check:
Code...
Check
To submit a prior authorization Login Here.

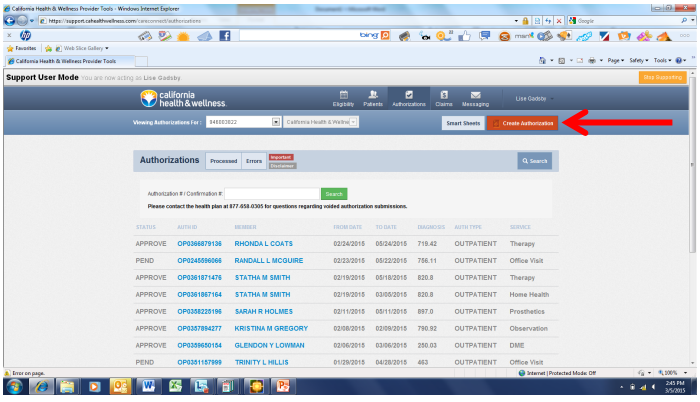
***Step 2*:** Enter your user name and password and click on "Login."



***Step 3*:** On the "Welcome" page click on the "Authorizations" icon.



***Step 4*:** Click on "Create Authorization" button.

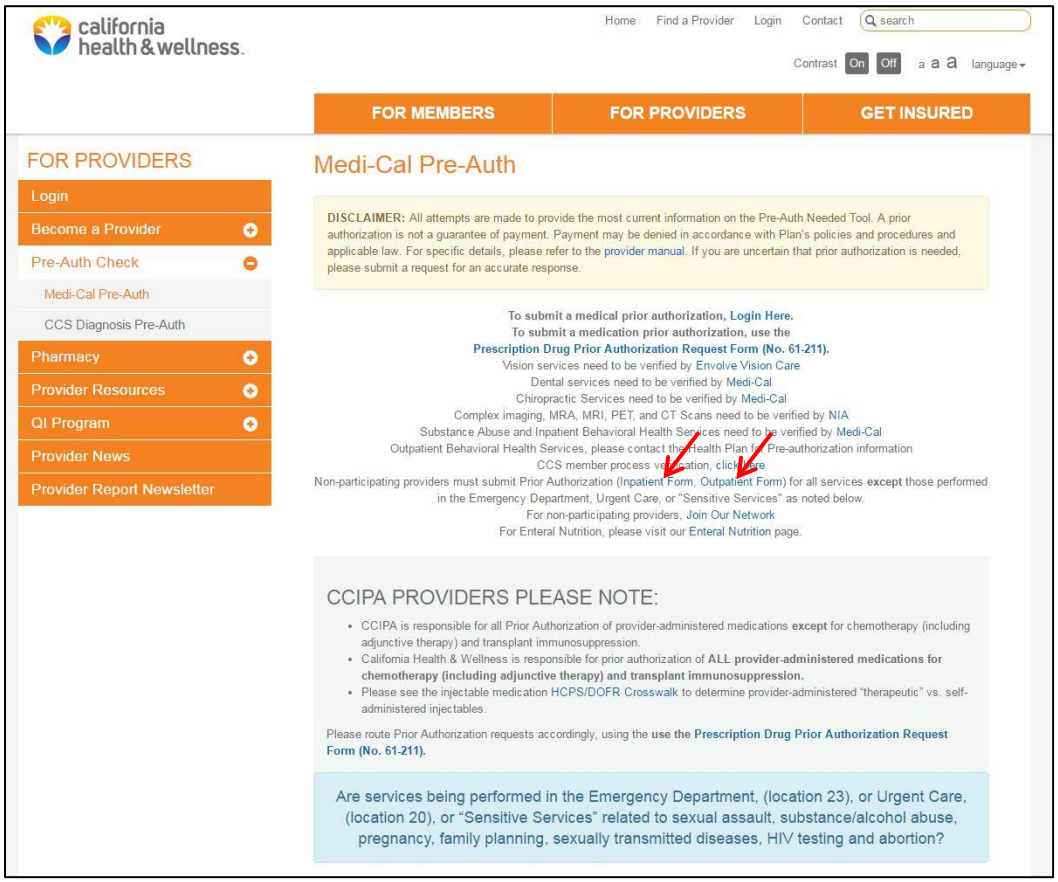


Follow the prompts on the following page to submit the prior authorization request.

Submitting Prior Authorization Requests by Fax – Providers are able to submit prior authorizations by sending a fax to **866-724-5057.** To submit by fax, please follow the instructions below:

For major organ transplant (MOT), a PCP, specialist or independent practice association (IPA) who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Medi-Cal approved, Health Net Transplant Performance Center (Center) for transplant evaluation. **The Center must send a fax to the Centene Central Transplant Unit (CTU) at 833-769-1140 to request prior authorization**. To submit by fax, please follow the instructions below:

***Step 1*:** Obtain forms for outpatient and inpatient prior authorization requests by clicking on the following links: inpatient authorization form; outpatient authorization form. Or start by visiting www.cahealthwellness.com/ and selecting the "For Providers" tab and selecting "Pre-Auth Check" from the pull-down menu. From the Pre-Auth Check page, click the "Medi-Cal" link. On the "Medi-Cal Pre-Auth" page, you will find links to the "Inpatient Form" and "Outpatient Form" located in the middle of the page. Please refer to the screenshot below. Click on the appropriate link to access the intended request form. These and other authorization-related forms are also available on the Resources and Prior Authorization web pages.



Step 2: Complete the appropriate authorization request form. The fields marked with an asterisk (*) means the field is required and must be completed. Note: When submitting authorizations by fax, please only enter the first nine digits (letters or numbers) of the Medi-Cal identification number.

Step 3: Once the form has been completed, please fax the form to 866-724-5057, or for major organ transplants (MOT), fax to the Centene Central Transplant Unit (CTU) at 833-769-1140.

How to submit Physician-Administered Drug Prior Authorization Requests

California Health & Wellness Plan Pharmacy Department is responsible for reviewing all physician-administered medication requests (except for those covered by CCIPA).

Select physician-administered medications require prior authorization to be approved for payment. Providers can determine whether prior authorization is required by entering the HCPCS code into the "Pre-Auth Check" tool located at www.CAHealthWellness.com.These and other authorization-related forms are also available on the Resources and Prior Authorization web pages

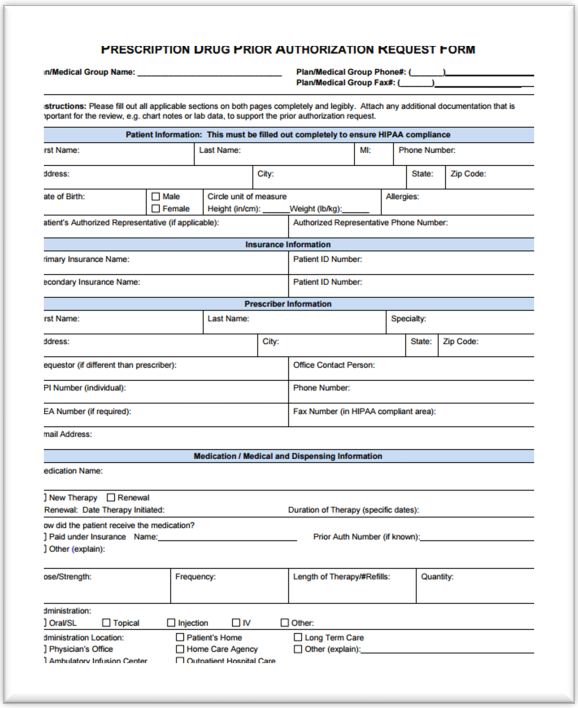
CCIPA:

- CCIPA is responsible for all prior authorizations of provider-administered medications except for chemotherapy (including adjunctive therapy) and transplant immunosuppression.
- Submit your request to Community Care IPA (CCIPA) by fax to 562-766-2001
- If assistance is needed, please contact them at 855-900-1224
- California Health & Wellness Plan is responsible for prior authorization of **provider-administered medications for chemotherapy (including adjunctive therapy) and transplant immunosuppression**. Submit a completed state-mandated Prescription Drug Prior Authorization Request Form (No. 61-211) by fax to California Health & Wellness Plan Pharmacy Department at (877) 259-6961

General pharmacy prior authorization information is located in Chapter 5: Pharmacy Program and on our website (Link: https://www.cahealthwellness.com/providers/pharmacy.html)

If a prior authorization is required, please follow the steps below.

- Complete the state-mandated Prescription Drug Prior Authorization Request Form (No. 61-211).
- The form can be found on the provider portal at www.CAHealthWellness.com under *For Providers > Pharmacy*.
- Submit a completed form by fax to California Health & Wellness Plan Pharmacy Department at 877-259-6961.



PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

n/Medical Group Name: _____ Plan/Medical Group Phone#: (_____)_____
Plan/Medical Group Fax#: (_____)_____

structions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is portant for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

rst Name:	Last Name:	MI:	Phone Number:
ddress:	City:	State:	Zip Code:
ate of Birth: ☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_____	Allergies:	
atient's Authorized Representative (if applicable):	Authorized Representative Phone Number:		

Insurance Information

rimary Insurance Name:	Patient ID Number:
econdary Insurance Name:	Patient ID Number:

Prescriber Information

rst Name:	Last Name:	Specialty:	
ddress:	City:	State:	Zip Code:
equestor (if different than prescriber):	Office Contact Person:		
PI Number (individual):	Phone Number:		
EA Number (if required):	Fax Number (in HIPAA compliant area):		
mail Address:			

Medication / Medical and Dispensing Information

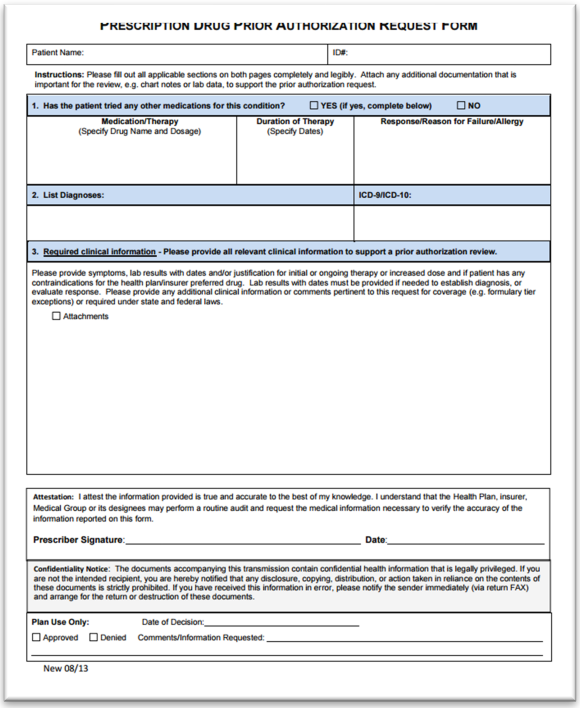
edication Name:

] New Therapy ☐ Renewal
Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

ow did the patient receive the medication?
] Paid under Insurance Name:_____ Prior Auth Number (if known):_____
] Other (explain):

ose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

dministration:
] Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:
dministration Location: ☐ Patient's Home ☐ Long Term Care
] Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
] Ambulatory Infusion Center ☐ Outpatient Hospital Care



PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**:_____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

New 08/13

- If approved, the prescriber is notified by fax
    a) If needed, California Health & Wellness Plan can coordinate the provision of approved medications to the provider for administration through our specialty pharmacy vendor.
    b) If the clinical information provided does not meet the coverage criteria for the requested medication, the member and the prescriber are notified of the reason for denial, listing any alternatives if appropriate, and are provided information regarding the appeal process.
- If a prior authorization is not required, please submit the drug claim.
- The medication might not require a prior authorization; however, the services or non-participating provider might require authorization (submit authorization request using the Outpatient Prior Authorization Process).

Authorization Determination Timelines

Upon receipt of a request for services, California Health & Wellness Plan decisions are made as expeditiously as the member's health condition requires. Decisions are rendered within the following timeframes based upon the type of request:

- Standard Authorization Decisions - For standard service authorizations, a decision and notification are made within five business days from the plan's receipt of requested information that is reasonably necessary to make a determination. This timeframe does not exceed 14 calendar days from receipt of the request (unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information within the designated time frame may result in an administrative denial of the requested service.
- Urgent/Expedited Pre-Service Requests - For urgent/expedited pre-service requests, a decision is made within 72 hours of the receipt of the request.
- Concurrent Review - For concurrent review, ongoing inpatient admission decisions are made within 72 hours of receipt of the request. The Plan may extend the timeframe for making urgent concurrent decisions in designated situations.

When a request is determined to be not medically necessary, the member, provider and facility (as applicable) are notified of the following:

- The decision
- The opportunity for the provider to request a peer-to-peer conversation with the medical director who made the decision by calling 1-877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number.)
- The ability for the member to file an appeal
    - The provider may file an appeal at the request of the member as described in the 'Your Rights' information attached to the denial letter

For more information on the steps providers can take in response to an adverse determination, use the following link: adverse determination.

Clinical Information Needed for Decision-Making

California Health & Wellness Plan requires providers to submit clinical documentation for all services that need prior authorization. California Health & Wellness Plan clinical staff requests the minimum clinical information necessary for clinical decision-making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Health & Wellness Plan is entitled to request and receive protected health

information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, procedure codes, where appropriate, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate

If additional clinical information is required beyond what was provided in the initial request, a California Health & Wellness Plan notifies the provider of the specific information needed to complete the authorization process.

Clinical Decisions

Utilization management decision-making is based on the appropriateness of care and service, as well as the existence of coverage. In addition, it involves referral of members to other programs providing coverage of specific conditions. California Health & Wellness Plan does not reward providers or other individuals for issuing denials of service or care.

Delegated providers must make certain that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the California Health & Wellness Plan Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and

established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in claim non-payment.

Medical Necessity

"Medical Necessity" means services reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in Title 22 CCR Sections 51340 and 51340.1, relating to Children's Health and Disability Prevention (CHDP) Services.

Review Criteria

California Health & Wellness Plan has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. Specialists representing a national panel from community-based and academic practice developed the InterQual appropriateness criteria. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

In the following instances, the Plan's Medical Director first consults available Corporate Medical Policy Statements: (1) determining benefit coverage and medical necessity for new and emerging technologies; (2) the new application of existing technologies; or (3) application of technologies for which no InterQual Criteria exists. The Centene Clinical Policy Committee develops these statements.

The Corporate Clinical Policy Committee (CPC) is responsible for evaluating new technologies or new applications of existing technologies for inclusion as medical necessity criteria. The CPC develops, disseminates and at least annually updates medical policies related to: medical procedures, behavioral health procedures, pharmaceuticals and devices. The CPC or assigned designee reviews appropriate information to make medical necessity decisions including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/Manual and input from relevant specialists and professionals who have expertise in the technology. Subsequent review is completed by the Plan to support compliance with state regulatory requirements. Providers are notified in writing through the provider newsletters and the practitioner web Portal (as applicable) of new

technology determinations made by the Plan. As with standard UM criteria, the treating provider may, at any time, request the medical policy criteria pertinent to a specific authorization by contacting the Medical Management Department or may discuss the UM decision with the Plan Medical Director. If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management Department at (877) 658-0305. For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number.

When determining benefit coverage and or medical necessity for a physical health request, factors such as Federal or State regulations may also apply. In these instances, criteria are applied in the following order as it pertains to the specific request:

A. Federal Regulation or Law
B. State Regulation or Law
C. State definition of medical necessity
D. Centene or Plan Clinical Policies
E. InterQual

In the case of no guidance from A-E, additional information that the applicable Health Plan Medical Director will consider, when available, includes:

1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
4. Medical association publications;
5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as AHRQ, Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, NICE, etc.;
6. Published expert opinions;
7. Opinion of health professionals in the area of specialty involved;
8. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:

A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook
D. Preferred Drug List (PDL)

To the extent there are any conflicts between Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions supersedes.

Long-Term Care/Skilled Nursing Facility Admission and Review Criteria

Prior authorization is required for admission to long-term care/skilled nursing facility and will be based on medical necessity. Long-term care is a covered benefit beginning December 2023. (Hospice services are a covered benefit and are not considered long-term care, regardless of the member's expected length of stay in a nursing facility.)

A. Member Status for Skilled Nursing Facility:

- Medically stable with medical or surgical comorbidities manageable and ***not requiring acute*** medical attention.
- Requires care that is directly related and reasonable for the presenting condition and /or illness.
- Expected improvement from medical and/or rehabilitative intervention within a reasonable and predictable period of time.
- Member who requires rehabilitative services must ***exhibit a decline in physical function*** in order for the rehabilitation services to be considered medically appropriate.

B. Minimum Program Requirements for Skilled Nursing Facility:

- Skilled Nursing at least daily and Skilled Therapy 1-2 hours per day at least five days per week.
- Medical practitioner, Nurse Practitioner, or Physician Assistant assessment or oversight required at least one or more per week.
- Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and/or rehabilitation therapists.
- Treatment Plan developed within two days of admission.
- Daily documentation of treatment and response to interventions with progress toward meeting goals.
- Medical specialty consultative services, pharmacy, and diagnostic services available.
- If a skilled nursing facility resident leaves, and then requires a return to a skilled nursing facility level of care due to medical necessity, the member has the right to return to the same skilled nursing facility where they previously resided under the leave of absence and bed hold DHCS policy.

C. Skilled Nursing Facility Leave of Absence and Bed Hold Policy:

- Reimbursement for leave of absence and bed hold follow DHCS Medi-Cal regulatory guidelines at www.dhcs.ca.gov/provgovpart/Pages/SkilledNursingFacilities.aspx for more information.

- Maximum time period:
  - A bed hold is limited to a maximum of seven days per hospitalization.
  - A leave of absence is limited to 18 days per calendar year.
- Refer to the DHCS website for more details.

Responding to Adverse Determinations

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at (877) 658-0305. For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number. Providers also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Providers may contact the Medical Director by calling our toll-free phone number. A case manager may also coordinate communication between the Medical Director and requesting provider.

A member, a member's representative or a provider acting on behalf of the member with written consent, may initiate the appeal process in response to California Health & Wellness Plan Notice of Action (NOA), which may be sent to:

California Health & Wellness Plan
Appeals Department
4191 East Commerce Way
Sacramento, CA 95834
(For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
Fax: 1-855-460-1009

Please also see the Chapter 17: Grievance and Appeals for further information about the member grievance and appeal process.

Radiology and Diagnostic Imaging Services

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, California Health & Wellness Plan has an extensive prior authorization and utilization program. California Health & Wellness Plan focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA
- MRI/MRA
- PET Scan

KEY PROVISIONS:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ***ordering*** physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Please call (877) 658-0305. (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) and follow the prompt for radiology authorizations. You can also use the following link (NIA) to an interactive website which may be used to obtain on-line authorizations.
Note: If you are part of an Independent Practice Association (IPA), please work with your IPA on the referral process.

Referrals to Specialists

The Primary Care Provider (PCP) is responsible for coordinating the healthcare services for California Health & Wellness Plan members. PCPs can refer a member to an in-network specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, **paper referrals *are not* required**. PCPs may refer members to a non-contracted/out of network provider in the event the appropriate specialist needed for the member's condition is not an in network specialist. However, PCPs must obtain prior authorization from California Health & Wellness Plan for referrals to out of network providers. To better coordinate a member's healthcare, California Health & Wellness Plan also encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

Note: If you are part of an Independent Practice Association (IPA), please work with your IPA on the referral process.

Second Opinion

California Health & Wellness Plan will reimburse for a second opinion from a qualified health professional within the provider network or arrange for the member to obtain a second opinion outside of the network. Members have a right to seek, and cannot be denied, a second opinion. Providers may contact California Health & Wellness Plan's Medical Management department to assist in the coordination of second opinions.

Assistant Surgeon

California Health & Wellness Plan may reimburse an assistant surgeon for services rendered based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family

requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

Services That Do Not Need Prior Authorization or Referral

Self-Referral Services

California Health & Wellness Plan permits members to obtain some services without a referral or prior authorization. The following services do not require prior authorization or referral from a provider:

- Emergency services including emergency ambulance transportation
- Certain Preventive services
- Basic prenatal care
- Treatment or Diagnosis of sexually transmitted diseases services
- HIV testing
- Well Women's health services
- Family planning
- Sensitive services for both women and men
- Covered optometric services with a participating provider

Note: Except for emergency, sensitive services and family planning services, the above services must be obtained through California Health & Wellness Plan network providers.

Emergency Care Services

Members may access emergency services at any time without prior authorization or prior contact with California Health & Wellness Plan. If members are unsure as to the urgency or emergency of the situation, they can contact their PCP and/or California Health & Wellness Plan 24-hour Nurse Triage Line for assistance; however, this is not a requirement to access emergency services. California Health & Wellness Plan contracts with emergency services providers as well as non-emergency providers who can address non-emergency care issues occurring after regular business hours or on weekends.

California Health & Wellness Plan defines an *emergency medical condition* as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

- Serious impairment of a bodily function
- Serious dysfunction of any bodily organ or part

Emergency services are covered by California Health & Wellness Plan when furnished by a qualified provider, including non-network providers, until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition is also covered by California Health & Wellness Plan. California Health & Wellness Plan covers emergency services irrespective of whether the provider is part of the California Health & Wellness Plan provider network. California Health & Wellness Plan does not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition.
- A representative from the plan or a network provider instructs the member to seek emergency services.

Post-Stabilization care does not require prior authorization. However, if a member is admitted to the hospital from the emergency room, California Health & Wellness Plan requires notification within one (1) business day of the admission.

The provider cannot bill, charge, or collect payment from a member for any emergency care services.

Sensitive Services (Including Women's Healthcare Services)

California Health & Wellness Plan provides direct access to in-network specialists who provide sensitive services for both women and men. This includes core services that provide women with routine and preventive healthcare services. Members can use their own PCP, any family planning service provider or women's healthcare provider for sensitive services without the need for a referral or a prior authorization. In addition, members can receive family planning services and related supplies from an out-of-network provider without any restrictions. Sensitive services include but are not limited to:

- Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations and sexually transmitted diseases;
- Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;
- Provision of contraceptive procedures and contraceptive supplies for both women and men by those qualified to do so under the laws of the State in which services are provided;

- Referral of members to physicians or health agencies for consultation, examination tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases as indicated;
- Immunization services where medically indicated and linked to sexually transmitted infections including but not limited to Hepatitis B and Chlamydia immunizations; and
- Abortions are a covered service and do not require authorization.

California Health & Wellness Plan makes every effort to contract with all local family planning clinic and providers and facilitates reimbursement whether the provider is in or out of network.

Concurrent Review and Discharge Planning

Nurses perform ongoing concurrent review for inpatient admissions through onsite, electronic medical record or telephonic methods, through contact with the hospital's utilization and discharge planning departments and with the member's attending physician when necessary. The nurse reviews the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions are made within 72 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review. However, the hospital should notify California Health & Wellness Plan within one business day of admission with complete information regarding the delivery status and condition of the newborn.

Hospital and Inpatient Facility Discharge Planning

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 for California Health & Wellness Plan members, including post-hospital care and member notification of patient rights.

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

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

Discharge Notification

Hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) must have policies and procedures in place when transitioning members from hospitals or inpatient facilities to their homes and other community-based settings.

Hospitals and inpatient facilities must notify the member's primary care provider of discharge from hospitals or inpatient facilities.

Information needed for discharge summary

When notifying the member's primary care provider of a discharge, provide the information below:

- Member name
- Identification (ID) number from patient's membership ID card
- Date of birth (DOB)
- Admission and discharge dates
- Attending physician name
- Attending physician phone number
- Diagnosis
- Follow-up appointment date, if known
- Discharge destination
- Responsible party at discharge
- Level of assistance required
- Discharge planning needs including equipment, service or other special training needs
- Medications, including dosage and frequency at discharge
- Facility name and phone number

Electronic medical records or administrative system

In accordance with the Provider Participating Agreement (PPA) and Federal regulation 42 CFR 482.24 section (d), hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

QHIO	Website
Los Angeles Network for Enhanced Services (LANES)	lanesla.org/
Manifest MedEx	manifestmedex.org/
Sacvalley MedShare	sacvalleyms.org/
San Diego Health Connect	sdhealthconnect.org/
Applied Research Works, Inc.	drupal.org/applied-research-works-inc

Health Gorilla, Inc.	healthgorilla.com/
Long Health, Inc.	longhealth.io/
Orange County Partners in Health-Health Information Exchange (OCPH-HIE)	ochealthinfo.com/ems/oc-meds/hie
Serving Communities Health Information Organization (SCHIO)	schio.org/

Retrospective Review

Retrospective review is an initial review of services already provided to a member, but for which authorization was not obtained. Retrospective review for inpatient services is conducted when a member has been discharged from an inpatient admission prior to notifying California Health & Wellness Plan and notification was timely and/or timely notification was not made due to extenuating circumstances. Retrospective review may also be conducted for outpatient services when authorization was not obtained due to extenuating circumstances. Requests for retrospective review must be submitted promptly. A decision is made within 30 calendar days following receipt of the request.

Community Based Adult Services (CBAS)

CBAS is an outpatient, facility-based program that delivers skilled nursing, social services, therapies, personal care, and support and nutrition services. Additional services may be provided if indicated or specified. California Health & Wellness Plan coordinates the administration of the assessment, which is used to determine eligibility for CBAS services.

The CBAS Eligibility Determination Tool (CEDT) is used to assess members for CBAS services. Partners in Care conducts a face-to-face assessment with the member. A determination is made based on completion of both the assessment and review of eligibility for services. If the member is determined to be eligible for CBAS services, the CBAS Center then conducts a 3-day assessment and develops an Individual Plan of Care (IPC). This assessment and IPC are used to determine the frequency of CBAS services. CBAS services may be authorized up to six months. Prior to the end of the six-month authorization period an updated IPC and request for additional services must be submitted.

The CBAS request form is available in the Prior Authorization and Provider Resources pages of the CAHealthWellness.com website. Fax the completed CBAS request form to 855-556-7909. Note: To facilitate the face-to-face assessment, providers should submit a recent history and physical with the request.

CBAS TREATMENT REQUEST FORM

Fax to:1-855-556-7909

If you have questions about how to complete this form, please call California Health & Wellness at 1-877-658-0305, and ask for Case Management.

X _____ Requesting Provider/CBAS Representative Signature

_____ Name (print) _____ Date (MMDDYYYY)

☐ Expedited Request - Please check if this is for a new participant who is hospitalized or anticipated to be admitted to a skilled nursing facility.

* *INDICATES REQUIRED FIELD*

MEMBER INFORMATION

Member Telephone Number *

Date of Birth * (MMDDYYYY)

Member ID/Medi-Cal ID *

Last Name, First

PROVIDER/CBAS FACILITY INFORMATION

Requesting Provider/CBAS Facility NPI *

Requesting Provider/CBAS Facility TIN

Provider/CBAS Facility Contact Name

Requesting Provider/CBAS Facility Address

City

ZIP Code

Requesting Provider/CBAS Facility Name

Telephone

Fax

AUTHORIZATION REQUEST/NOTIFICATION (S5102)

Start Date (MMDDYYYY)	End Date (MMDDYYYY)	Quantity per Month	Diagnosis Code * (ICD-10)
Start Date (MMDDYYYY)	End Date (MMDDYYYY)	Quantity per Month	Diagnosis Code * (ICD-10)
Start Date (MMDDYYYY)	End Date (MMDDYYYY)	Quantity per Month	Diagnosis Code * (ICD-10)
Start Date (MMDDYYYY)	End Date (MMDDYYYY)	Quantity per Month	Diagnosis Code * (ICD-10)
Start Date (MMDDYYYY)	End Date (MMDDYYYY)	Quantity per Month	Diagnosis Code * (ICD-10)

SERVICES *

Face-to-Face Assessment (T1023)

☐ Initial

☐ Modification

[1] **Please attach copy of History and Physical (H&P) with Face to Face Assessment request.**

3-Day Individual Plan of Care (IPC) Assessment for New CBAS (H2000)

☐ Initial

Medical Day Care Services (S5102)

☐ Initial

☐ Continuation/Renewal[2]

☐ Modification[2] (Increase/Decrease)

☐ Reinstate Services

☐ Transfer

[2] **Please attach IPC, participant attendance records and transfer reason (if applicable) for continued authorization requests.**

FOR PRIOR AUTHORIZATION REQUEST ONLY: ALL REQUIRED FIELDS MUST BE FILLED IN. INCOMPLETE FORMS WILL BE REJECTED. COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: Please check member eligibility prior to rendering services. A prior authorization is not a guarantee of payment. Payment may be denied in accordance with Plan's policies and procedures applicable law.

Confidentiality: Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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Palliative Care Services

The palliative care team screens members for eligibility and enrollment criteria. Eligible members at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or liver disease. Life expectancy is 12 months or less, health status continues to worsen and the emergency department (ED) 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 in addition to current benefits. CHWP's palliative team and approved palliative care providers work with other health care team members and services to coordinate palliative services with current medical services.

Providers can refer an eligible Medi-Cal member to the palliative care program. Send a Palliative Care Referral Form by email to Cindy.tatu@healthnet.com, Stephanie.M.Espinoza@centene.com and Gabriele.Pierce@healthnet.com. The referral form is listed under > Manuals, Forms and Resources.

Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in section A. below, and at least one of the four requirements outlined in section B.

Members under age 21 who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in section C. below, consistent with the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:

a) Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
b) Participate in advance care planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive heart failure (CHF): Must meet (a) and (b)
   a) The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
   b) The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b)
   a) The member has a forced expiratory volume (FEV) of one less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   b) The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced cancer: Must meet (a) and (b)
   a) The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b) The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver disease: Must meet (a) and (b) combined or (c) alone
   a) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
   b) The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

Must meet 1. and 2. listed below. Members under age 21 may be eligible for palliative care and hospice services concurrently with curative care.

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
   a) Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or

b) Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
c) Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
d) Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

CHAPTER 8: BILLING AND CLAIMS SUBMISSION

Overview

California Health & Wellness Plan strives to process its providers' claims quickly, efficiently and accurately, and we have streamlined much of this process to ease the administrative burden on our providers. By the same token, as a California Health & Wellness Plan provider, understanding how the claims and billing process works will help you make sure that your claim is processed quickly. Clean and uncontested claims are processed within 30 business days after receipt of the claim.

In this Manual, we refer to a **claim** as a request for reimbursement, either electronically or by paper, for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim

This chapter contains a description of some of the basic procedures that providers must understand to process a claim with California Health & Wellness Plan, including:

- Procedures for Claim Submission
- Requirements for Timely Filing
- Procedures for Electronic Claims Submission
- Online Claim Submission
- Paper Claim Submission Requirements
- Coding and Documentation Requirements
- Code Auditing and Editing
- Procedures for Requesting Reconsiderations, Claim Disputes and Claims Corrections
- Key Billing Tips and Reminders

To obtain more information, providers can contact our Claims Department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). Please also see Chapter 2 of this Manual: Resources for Providers, for information on how to register and access California Health & Wellness Plan's secure Provider Portal, and for additional contact information on topics that are of interest to providers and their staff.

Procedures for Claim Submission

Timely Filing

Providers must submit first time claims no later than the sixth month following the month of service. When California Health & Wellness Plan is the secondary payer, the claims must be received no later than one year after the month of service to permit the provider to obtain proof of payment, partial payment or non-liability of the carrier. Claims received outside of these timeframes will be denied for untimely submission.

A request for adjustment, corrected claim or reconsideration of an adjudicated claim must be received no later than 365 days following the date of payment or denial of the claim. If favorable resolution of a claim is not obtained, a grievance or complaint concerning the processing or payment of the claim may be filed.

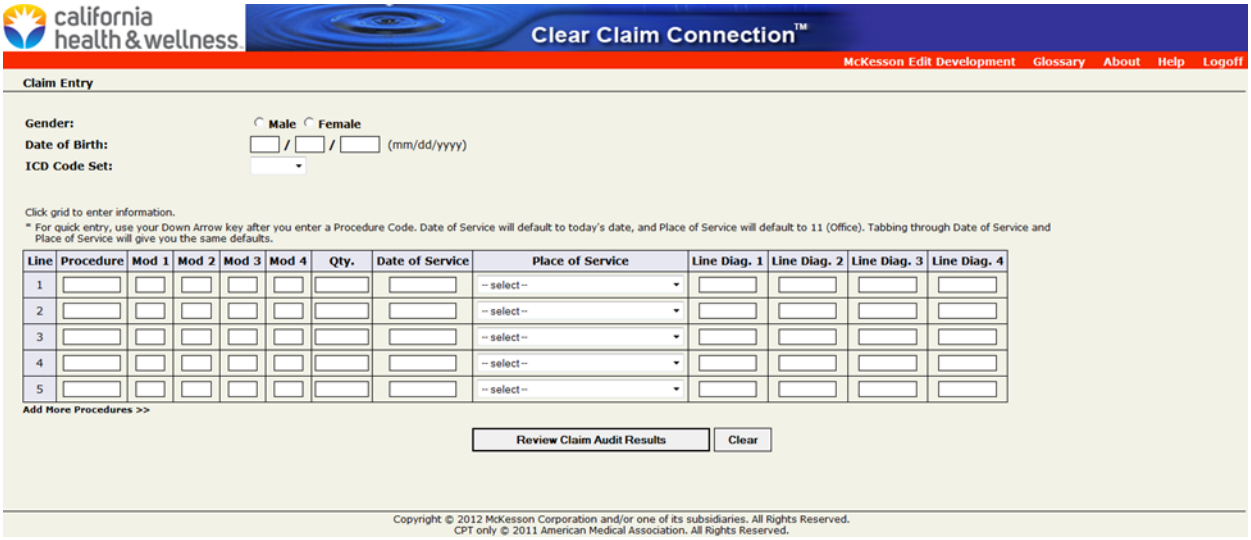
Prior processing will be upheld for provider claim requests for reconsideration or disputes received outside of the timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster
- Mechanical or administrative delays or errors by California Health & Wellness Plan or the California Department of Health Care Services (DHCS) and/or the California Department of Managed Care (DMHC)
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered
    - Consideration is granted in this situation only if all of the following conditions are met:
        - The provider's records document that the member refused or was physically unable to provide their ID card or information
        - The provider can substantiate continuous pursuit of reimbursement from the patient until eligibility was discovered
        - The provider can substantiate that a claim was filed within not later than the sixth month following the month of service of discovering Plan eligibility
        - The provider has not filed a claim for this member prior to the filing of the claim under review
        - An Administrative Law Judge (ALJ) proof of timely filing

All claims (Paper, Web or Electronic) filed with California Health & Wellness Plan are subject to verification procedures. These include but are not limited to verification of the following:

- All claims are subject to 5010 validation procedures based on CMS and Medi-Cal requirements.
- All required fields are completed on the current industry standard paper CMS 1500 Claim Form (HCFA), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted individually or in a batch on our Secure Provider Portal.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
    - The date of service
    - Provider type/specialty billing
    - Bill type
    - Age/sex of the patient
- All Diagnosis Codes are complete to their highest number of digits available (4th or 5th digit). Be sure to enter the primary diagnosis for which the claimed procedure(s) applies as the first diagnosis on the claim form.
- Principal Diagnosis billed reflects an allowed Principal Diagnosis as defined in the current volume of ICD-9 CM, or ICD-10 CM for the date of service billed.
    - For a CMS 1500 claim form, this criteria looks at all procedure codes billed and the diagnosis to which they are pointing. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis code, that service line will deny.
    - All inpatient facilities are required to submit a **Present on Admission (POA)** indicator for the principal and each secondary diagnosis code submitted on a claim, unless the code is exempt from POA reporting. POA information is stored and used to identify health care acquired conditions. Providers should refer to the *ICD-9-CM or ICD-10 Official Guidelines for Coding and Reporting* for national POA coding standards, which apply also to Medi-Cal. Claims are denied (or *rejected*) if the POA indicator is invalid.
- The Member identification number is located in Box 1A of the paper CMS 1500 claim form and Loop ID 2010 BA Segment NM109 of the 837p.
- A Member is eligible for services under California Health & Wellness Plan during the time period in which services were provided.
- Appropriate authorizations must be obtained for the services performed.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

To assist providers in determining whether their claims might be approved, California Health & Wellness Plan has made available a claims editing tool for providers to use on its website. Clear Claim Connection is an online claims edit tool that is available on California Health & Wellness Plan's secure Provider Portal, which can be accessed by visiting http://www.cahealthwellness.com/for-providers/provider-login/ and logging on to the secure Provider Portal (for information about how to register for the secure Provider Portal, use the following link: Portal registration). This resource enables providers to test whether a claim will be allowed by entering certain parameters, including: sex, date of birth, procedure codes, place of service, and diagnosis codes. Once this data has been entered, the provider can select the Review Claims Audit Results tab and Clear Claim Connection will respond with either a message that the claim would be allowed ("Allow") or disallowed (Disallow") based upon the information provided. The image below displays the Clear Claim Connection screen:



Procedures for Electronic Submission

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs:
    - Eliminates the need for paper claim submission

    - Reduces claim re-work (adjustments)
- Receipt of clearinghouse reports as proof of claim receipt
- Faster transaction time for claims submitted electronically
- Validation of data elements on the claim format

All the same requirements for paper claim filing apply to electronic claim filing. Claims not submitted correctly or not containing the required field data will be rejected and/or denied.

Electronic Claim Submission

Providers are encouraged to participate in California Health & Wellness Plan's Electronic Claims/Encounter Filing Program through Centene. California Health & Wellness Plan (through Centene) has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, California Health & Wellness Plan (through Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

California Health & Wellness Plan
c/o Centene EDI Department
(800) 225-2573, extension 6075525
Or by e-mail at: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to make certain all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Important Steps to a Successful Submission of EDI Claims

- Select clearinghouse to utilize or California Health & Wellness Plan's website
- Contact the clearinghouse to inform them you wish to submit electronic claims to California Health & Wellness Plan
- Inquire with the clearinghouse regarding what data records are required
- Verify with Provider Services at California Health & Wellness Plan that the provider is set up in the California Health & Wellness Plan system before submitting EDI claims
- You will receive two reports from the clearinghouse
    - ALWAYS review these reports daily. The first report will indicate the claims that were accepted by the clearinghouse and are being transmitted to California Health & Wellness Plan, as well as those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by California

Health & Wellness Plan. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted correct and resubmit.

- MOST importantly, all claims must be submitted with provider identifying numbers. See the companion guide on the California Health & Wellness Plan website for claim form instructions and claim forms for details (use the following link: companion guides).

NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the fields are empty.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this Manual. This includes the following:

- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
  - The date of service
  - Provider type/specialty billing
  - Bill type
  - Age/sex of the patient
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).

Please see the section in this chapter on claims submission procedures for more details: claims submission. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. More information on electronic transactions and available clearinghouses is accessible on California Health & Wellness Plan's website at www.cahealthwellness.com by using this link (electronic transactions). The Companion Guide is located on www.cahealthwellness.com and can be accessed by using the following links (837 Companion Guide and 837 Companion Guide Addendum).

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to California Health & Wellness Plan, all EDI claims must first be forwarded to one of California Health & Wellness Plan's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. **It is very important to review this error report daily to identify any claims that were not transmitted to California Health & Wellness Plan**. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to California Health & Wellness Plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to California Health & Wellness Plan by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). **It is very important to review this report daily**. The report shows rejected claims and these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to California Health & Wellness Plan.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid Electronic Claim Record Rejections

All claim records sent to California Health & Wellness Plan must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by California Health & Wellness Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline, not to exceed the sixth month following the month of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at (800) 225-2573 Ext. 6075525 or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

The California Health & Wellness Plan Companion Guides for electronic billing are available on our website. Use the following link (companion guides) for more details on electronic transactions.

Exclusions

Excluded Claim Categories **The following items are excluded from EDI Submission Options, but may be submitted via the secure Web Portal or on a paper claim**
Claim records requiring supportive documentation or attachments (i.e., consent forms) Note: **COB claims can be filed electronically when coordinating between one other payer.** If not submitted electronically, the primary payer EOB must be submitted with the paper claim.
Medical records to support billing miscellaneous codes
Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics); Provider is required to submit the invoice with the claim
Claim for services requiring clinical review (e.g. complicated or unusual procedure) Provider is required to submit medical records with the claim
Claim for services requiring documentation and a Certificate of Medical Necessity (e.g. Oxygen, Motorized Wheelchairs)

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Clearinghouses Submitting Directly to California Health & Wellness Plan	Ability (Inovalon) Availity
California Health & Wellness Plan Payer ID	68069 NOTE: Please reference the vendor provider Manuals at www.cahealthwellness.com for their individual payer ID's.

General EDI Questions:	Contact EDI Support at (800) 225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@centene.com.

Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at (800) 225-2573 Ext. 6075525 or via e-mail at EDIBA@centene.com.
Remittance Advice Questions:	Contact California Health & Wellness Plan Provider Services at 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) or the secure Provider Portal at www.cahealthwellness.com
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Services in writing at: California Health & Wellness Plan PO Box 4080 Farmington, MO 63640-3835

Electronic Secondary Claims

California Health & Wellness Plan has the ability to receive coordination of benefit (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (5010 Format):

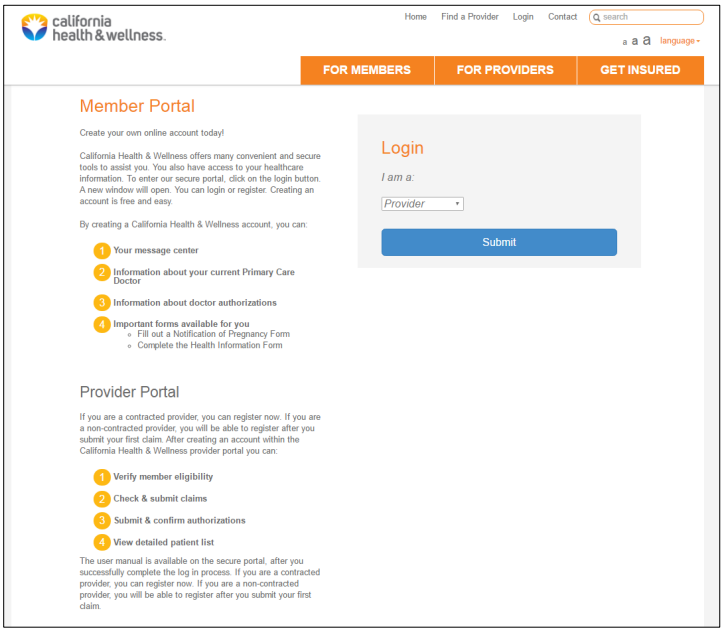
COB Field Name The below should come from the primary payer's Explanation of Payment	837I - Institutional EDI Segment and Loop	837P - Professional EDI Segment and Loop
COB Paid Amount	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=A8, map AMT02	If 2320/AMT01=A8, map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01=EAF, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR	If 2320/AMT01=EAF, map AMT02
COB Patient Paid Amount		If 2320/AMT01 = F5, map AMT02

COB Patient Paid Amount Estimated	If 2300/AMT01=F3, map AMT02	
Total Claim Before Taxes Amount	If 2400/AMT01 = N8, map AMT02	If 2320/AMT01 = T, map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02 with a Y

Procedures for Online Claim Submission

For providers who have Internet access and choose not to submit claims via EDI or paper, California Health & Wellness Plan has made it easy and convenient to submit claims directly to us on our secure Provider Portal at www.cahealthwellness.com.

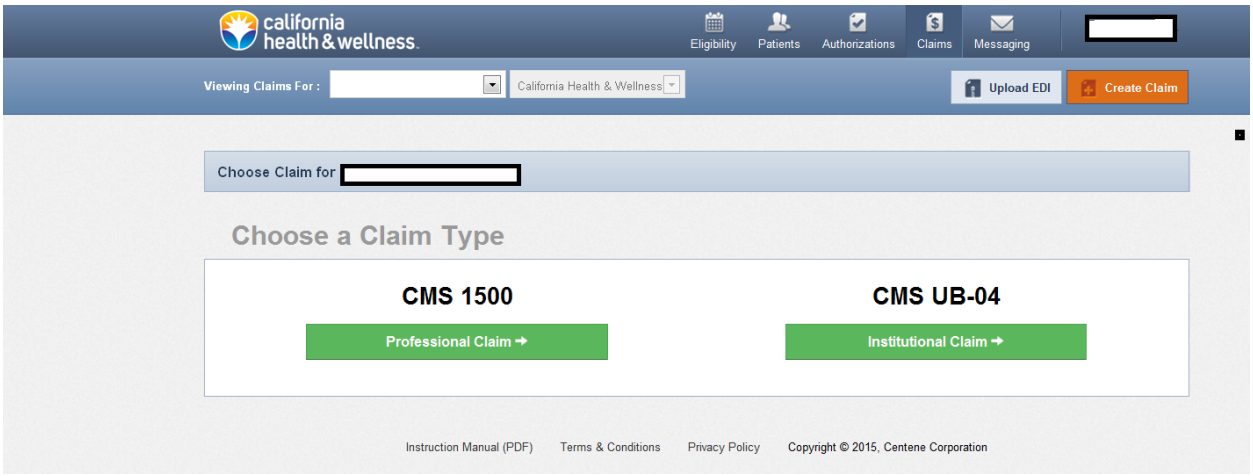
You must request access to our secure site by registering for a user name and password and you must select the Claims Role Access module. To register, please go directly to www.cahealthwellness.com/for-providers/provider-login/. If you have technical support questions, please contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).



Once you have access to the secure Portal you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims.

The image below displays a screenshot of what providers will view once they have access to the claims module of the secure Portal. To file a claim online:

- Please choose the claim type (CMS 1500 or CMS UB-04)
- Fill in the required data: all diagnosis, procedure, modifier, location (place of service), revenue, type of admission, source of admission codes valid for:
    - The date of service
    - Provider type/specialty billing
    - Bill type
    - Age/sex of the patient
- All diagnosis codes are to their highest number of digits available (4th or 5th digits)



EFT and ERA

- California Health & Wellness Plan partners with PaySpan to provide Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers. EFT and ERA services help providers reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straightforward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:

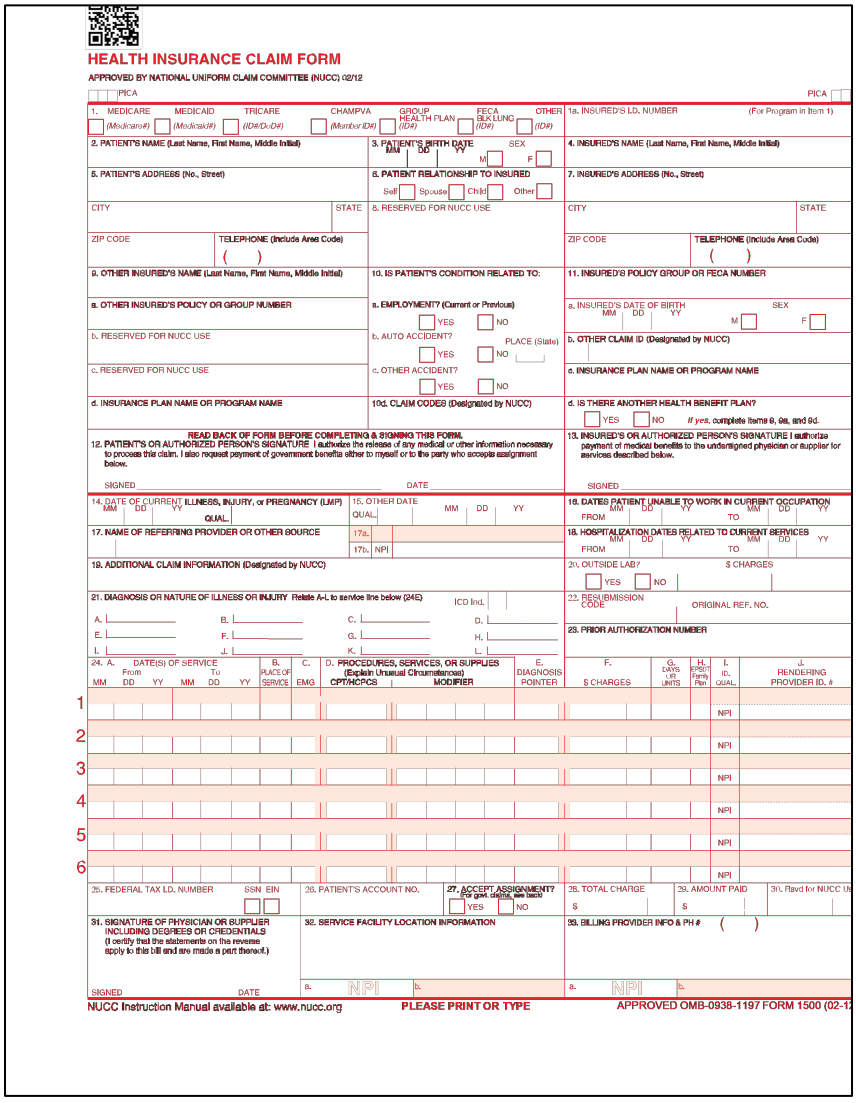
- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for Manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow

- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported.
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily
- For more information on our EFT and ERA services, please visit our website at www.cahealthwellness.com, contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) or directly contact PaySpan at 877-331-7154

Paper Claim Form Requirements

Claim Forms

California Health & Wellness Plan only accepts the CMS 1500 (02/12) and CMS UB-04 paper claim forms. Other claim form types will be rejected and returned to the provider.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Professional providers and medical suppliers complete the CMS 1500 (02/12) form and institutional providers complete the CMS UB-04 claim form. California Health & Wellness Plan does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be on the original red and white version to facilitate clean acceptance and processing. Black forms will not be accepted. Paper claims must be typed or printed with size 10 or 12 Times New Roman font with NO HIGHLIGHTING, ITALICS, or BOLD text.

Please check to see that the text is aligned appropriately in order to avoid delays or errors in reading the information. Hand-written claims will not be accepted. Some claims may require additional attachments. To reduce document-imaging time, please refrain from utilizing staples when attaching multiple page documents. Be sure to include all supporting documentation when submitting your claim. All documents should be submitted in paper form as no form of electronic media is accepted and will be sent back to the provider. If you have questions regarding what type of form to complete, contact California Health & Wellness Plan Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Submit claims to California Health & Wellness Plan at the following address:

First Time Claims, Corrected Claims, Reconsideration Request, and Claim Dispute Forms:

California Health & Wellness Plan
Claim Processing Department
P. O. Box 4080
Farmington, MO 63640-3835

California Health & Wellness Plan encourages all providers to submit claims electronically. Our Companion Guides for electronic billing are available on our website at www.cahealthwellness.com. Paper submissions are subject to the same edits as electronic and web submissions.

Paper Claim Rejections vs. Denials

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied.

A **REJECTION (CONTESTED CLAIM)** is defined as an **unclean** claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website and can be accessed by using the following links: 837 Companion Guide and 837 Companion Guide Addendum. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1. Rejections will not enter our

claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

If all edits pass and the claim is accepted, it will then be entered into the system for processing.

A **DENIAL** is defined as a claim that has passed edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below and a more comprehensive list with explanations can be located in Appendix 2.

Claim Coding/Documentation Requirements

Coding of Claims/Billing Codes

California Health & Wellness Plan requires all claims to be submitted using codes from the current version of ICD-9-CM, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code inappropriate for the age or sex of the member
- Diagnosis code missing the highest level specificity required
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Note, when California Health & Wellness Plan (CHWP) receives a Medi-Cal claim with both a National Drug Code (NDC) and a HCPCS code, CHWP applies line-level claim edits to determine:

- Is the NDC valid?
- Is the HCPCS code valid?
- Is the NDC/HCPCS code combination valid?

If the response to any of the above questions indicates an invalid code or invalid code combination, CHWP will contest the claim to ask for corrected billing.

Consent Forms Required with Claims

Consent forms may be required and should be included with the claim during the time of admission:

Consent forms and billing tips are located on the Medi-Cal website at:

- Sterilization Consent Form, including instructions for completing the form (tips and reminders)
- Hysterectomy Consent Form information, as well as billing information for hysterectomy services

We recommend that providers notify California Health & Wellness Plan 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

When required data elements are missing or are invalid, claims will be rejected or denied by California Health & Wellness Plan for correction and re-submission.

- For EDI claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason(s) for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).
- Claims for billable services provided to California Health & Wellness Plan members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Code Auditing and Editing

California Health & Wellness Plan uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software or Medi-Cal guidelines will be denied.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits); In addition to using the AMA's CPT Manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons)
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario
- Nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services – Identifies services that have been unbundled

Example: Unbundling Urinalysis tests. If any combination of urinalysis codes 81002, 81003, 81005 or 81015 are billed by the same provider, for same date of service, the software will bundle the component codes into the more comprehensive code 81000 or 81001, whichever is the most applicable.

Code	Description	Status
81002	Urinalysis, non-automated, without microscopy	Disallow
81003	Urinalysis, automated, without microscopy	Disallow
81005	Urinalysis, qualitative or semi-quantitative, except immunoassays	Disallow
81015	Urinalysis, microscopic only	Disallow
81000 or 81001	Urinalysis, by dip stick or tablet reagent, with microscopy Urinalysis, automated, with microscopy	Allow

Explanation: The total reimbursement for any combination of codes 81002, 81003, 81005 or 81015, when billed by the same provider, for the same recipient and date of service, will not exceed the allowable reimbursement for complete test codes 81000 or 81001.

Bilateral Surgery – Identical procedures performed on bilateral anatomical sites during same operative session:

Example:

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Disallow
69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

Explanation: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). ***Note:*** *Modifiers RT (right), or LT (left) should not be billed for bilateral procedures.*

Duplicate Services – Submission of same procedure more than once on same date of service that cannot be or are normally not performed more than once on same day:

Example: Excluding a Duplicate CPT

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx
- It is clinically unlikely that this procedure would be performed twice on the same date of service

Evaluation and Management Services (E/M) – Submission of E/M service either within a Global Surgery Period or on the same date of service as another E/M service:

Global Surgery:

Procedures that are assigned a 90-day global surgery period are designated as major surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are *not* recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the Medi-Cal Fee Schedule with an asterisk.

Example: Global Surgery Period

Code	Description	Status
27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, medical decision making of low complexity; Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) and patient's and/or family's needs; Problem(s) are low/moderate severity; Physicians spend 15 minutes face-to-face w/patient and/or family	Disallo w

Explanation:

- Procedure code 27447 has a global surgery period of 90 days
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period

Example: E/M with Minor Surgical Procedures

Code	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface	Allow
99213 DOS=01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, medical decision making of low complexity; Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs; Problem(s) are low/moderate severity; Physicians spend 15 minutes face-to-face with patient and/or family	Disallow

Explanation:

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure
- Procedure 99213 is submitted with the same date of service
- When a minor procedure is performed, the evaluation and management service is considered part of the global service

Same Date of Service

One evaluation and management service is recommended for reporting on a single date of service.

Example: Same Date of Service

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, medical decision making of high complexity; Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs; Usually	Allow

	problem(s) are moderate/high severity; Physicians spend 40 minutes face-to-face with patient and/or family	
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making; Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs; Presenting problem(s) are low severity; Physicians spend 30 minutes face-to-face with patient/family	Disallow

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit
- Procedure 99242 is used to report an office consultation for a new or established patient
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services

  Interventions, provided during an evaluation and management service, typically include the components of an office consultation

NOTE:

Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period

Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure

Modifier -79 is used to report an unrelated procedure or service by the same physician during the post-operative period

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended

When modifier -79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended

Modifiers – Codes added to the main procedure code to indicate the service has been altered by a specific circumstance:

Modifier -26 (professional component)

Definition: Modifier -26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS=Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation:

- Procedure code 78278 is valid with modifier -26
- Modifier -26 will be added to procedure code 78278 when submitted without modifier -26

Modifier -80 (assistant surgeon)

Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

Code	Description	Status
42820-80	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation:

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

Level III HCPCS Codes

Level III HCPCS codes are referred to as Local Codes. These five digit codes are alphanumeric and are available on the Medi-Cal fee schedule and throughout the Medi-Cal Provider Manuals. Revisions or updates are published in the Medi-Cal newsletters. California Health & Wellness Plan will accept these local codes until Medi-Cal is able to make policy and reimbursement determinations and crosswalk them to HIPAA compliant codes. For more information about HCPCS Level III coding for Medi-Cal services, use the following link (local codes).

- Remediation Code Conversion Local Codes are noted as Level II & III codes to a CPT code. This will be updated by the State in phases. Each phase will be updated and California Health & Wellness Plan will follow and accept updated codes for submission once Medi-Cal's Transition Period is established.

CODE SETS:

- Code Sets change each calendar year. Medi-Cal bulletins address this as "CPT CODES NOT YET ADOPTED". All updates pending, California Health &Wellness follows the state guidance when to replace each code set, upon Medi-Cal's announcements and or Bulletins.

California Children's Services (CCS) Carve-Out Claims

The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS). CCS pays for CCS approved services that are associated with an eligible diagnosis. CCS only reimburses for services rendered by CCS-paneled providers and approved by CCS. CCS services are not covered under the California Health & Wellness Plan. California Health & Wellness Plan does not pay for services that are covered by CCS. For more information, please see Chapter 6: State and County Programs by using the following link: CCS.

CHDP Claims

Child Health and Disability Prevention (CHDP) services rendered to California Health & Wellness Plan members should not be billed to the State's CHDP program. For more information about the CHDP program, use the following link to a description of the CHDP program.

Claims should be submitted as outlined in the billing and claims submission sections of this Manual. Code conversion information is also available to help with filling out the CMS-1500 form.

For more information about CHDP, please use the following link: CHDP Manual.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

Corrected claims and all claim requests for reconsideration must be submitted **not later than the 365 days following the date of payment or denial of the claim**. Corrected claims or adjustment requests should be resubmitted in their entirety, not just the corrected or disputed services. If a paper claim has been rejected, the provider should submit a copy of the rejection letter with the corrected claim.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are five effective ways in which a provider can contact California Health & Wellness Plan.

- Review the claim in question on the secure Provider Portal. Participating providers who have registered for access to the secure Provider Portal can access claims to obtain claim status, submit claims or submit a corrected claim.
- Contact California Health & Wellness Plan Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a simple request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly.

- Submit an adjusted or corrected claim to California Health & Wellness Plan
    - Corrected claims must clearly indicate they are corrected in one of the following ways:
        - Submit corrected claim via the secure Provider Portal
        - Follow the instructions on the Portal for submitting a correction.

- Submit corrected claim electronically via Clearinghouse
    - Institutional Claims (UB): Field CLM05-3 = 7 and REF*F8 = Original claim number should be listed in the corresponding field box 64 (UB04) or Box 22 with resubmission code (CMS1500)
    - Professional Claims (CMS): Field CLM05-3 = 6 and REF*F8 = Original claim number

- Mail corrected claims to:

California Health & Wellness Plan
ATTN: CORRECTED CLAIMS
P.O. Box 4080
Farmington, MO 63640-3835

- Paper claims must include original EOP with the resubmission.
- Failure to include the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

- Submit a "Request for Reconsideration" to California Health & Wellness Plan:
  - Requests for Reconsideration should be mailed to California Health & Wellness Plan at the address below:

    California Health & Wellness Plan
    ATTN: RECONSIDERATIONS
    P.O. Box 4080
    Farmington, MO 63640-3835

  - A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
  - The claim form **should not** be resubmitted; however, the claim number must be referenced in the documentation.
  - The request must include sufficient identifying information which includes, at a minimum, the patient name and patient ID number, date of service, total charges, provider name and provider tax identification number.

Provider Claim Disputes

To initiate a dispute, a provider should submit a Provider Dispute Resolution Form in writing, within 365 days of the action precipitating the grievance or complaint, identifying the claims involved and specifically describing the disputed action or inaction regarding such claims. To access the form, use this link: Provider Dispute Resolution Form.

- The documentation must also include a detailed description of the reason for the request.
- Unclear or non-descriptive requests could result in no change in the processing, a delay in the research or delay in the reprocessing of the claim.

To submit a Provider Dispute Resolution Form for a claims issue:

- Mail the form to California Health & Wellness Plan at the address below:

  California Health & Wellness Plan
  ATTN: CLAIMS DISPUTES
  P.O. Box 4080
  Farmington, MO 63640-3835

- A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

  Providers wishing to dispute a claim must complete the Provider Dispute Resolution Form located at: www.cahealthwellness.com. Use this link to access the Provider Dispute Resolution Form.

- To expedite processing of your dispute, please include the original request for reconsideration letter and the response.
- The claim form **should not** be submitted; however, the claim number must be referenced in the documentation.
- All documents should be submitted in paper form as no form of electronic media is accepted and will be sent back to the provider.

If the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

California Health & Wellness Plan processes and finalizes all corrected claims, requests for reconsideration and disputed claims to a paid or denied status within 45 working days of receipt of the corrected claim, request for reconsideration or claim dispute.

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, instead of the Provider Dispute Resolution Form, please call 877-658-0305.
- Mail the completed form for **claims** to:

California Health & Wellness
Attn: Claim Dispute
P.O. Box 4080
Farmington, MO 63640-3835

Other provider disputes not involving claims should be mailed to the California Health & Wellness Plan Appeals Department. The Provider Dispute Resolution Form can also be used for other non-claims related issues. For more information about disputes regarding member issues that are not related to claims, please use the following link to the grievance and appeals section of this Manual (grievance and appeals).

Submitting a Complaint to the Department of Managed Healthcare Services (DMHC)

If the provider is not satisfied with the final medical claims dispute review, the provider may submit a complaint to the Department of Managed Healthcare Services using this link: https://wpso.dmhc.ca.gov/provider/AllLogin.aspx. For details on how to submit a complaint, visit http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx

Billing Tips and Reminders

Ambulance

- Non-Emergent
    - Home to Provider's office - Prior authorization required. For more information on how to submit a prior authorization request, use the following link (prior authorization request).

- Facility-to-Facility - Prior authorization required. For more information on how to submit a prior authorization request, use the following link (prior authorization request).

- Emergent
  - 911 - No prior authorization required. For more information on how to submit a prior authorization request, use the following link (prior authorization request).

Other billing requirements:

- Must be billed on a CMS 1500
- When billing for Non-Emergent Medical Transportation use location 99
- Emergent land ambulance must be billed in place of service 41
- Emergent air/water ambulance transportation should be billed in location 42
- Non-Emergent transportation via Ambulance requires prior authorization
- Pricing modifiers such as UJ (services provided at night) must be billed in the first modifier position to receive the appropriate reimbursement, unless otherwise specified in the following Medi-Cal manuals: Medical Transportation – Ground (mc tran gnd), Medical Transportation – Air (mc tran air).
- Institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates; the first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

  D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;

  E = Residential, domiciliary, custodial facility (other than 1819 facility)

  G = Hospital based ESRD facility

  H = Hospital

  I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport

  J = Freestanding ESRD facility

  N = Skilled nursing facility

  P = Physician's office

  R = Residence

  S = Scene of accident or acute event

  X = Intermediate stop at physician's office on way to hospital (destination code only)

Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 claim form. Effective June 1, 2015, Ambulatory Surgery Centers are to submit

charges on the UB-04 claim form. If billed on CMS(HCFA) 1500 claim form, claims will deny as not billed on appropriate form type

- Must be billed in place of service 24

Anesthesia

- Bill total number of minutes in Block 24G of the CMS 1500 Claim Form. Failure to bill total number of minutes may result in incorrect reimbursement or claim denial. Units will no longer be accepted.
- When two members of a provider group each render anesthesia services on the same member, on the same date of service, each NPI will need to be billed on a separate claim form.
- All anesthesia claims require a modifier. Failure to use the applicable modifier(s) will result in the claim being rejected or denied.
- When two or more modifiers are necessary to identify the anesthesia services, use the appropriate modifiers. DO NOT USE Modifier 99.
- Refer to the Medi-Cal Anesthesia Manual for more information on modifier requirements including modifier AG, QK, QX, QZ and Physical Status modifiers P1-P5. Use the following link to access the Medi-Cal Anesthesia Manual: anesthesia.
- For OB anesthesia service CPT-4 01967, bill only the **actual** time in attendance as per page 2 of the Medi-Cal manual **Anesthesia** (anest). Failure to do so will result in the service being denied.

Authorization Requests

- The California Health & Wellness Plan Prior Authorization fax forms request member information.
- Please enter only the first nine digits of the member's Medi-Cal identification number
- Please use the following links to access the California Health & Wellness Plan Inpatient Authorization Form and the California Health & Wellness Plan Outpatient Authorization Form.

CBAS

- Submit claim on a UB04 form using the appropriate HCPC codes.
- All HCPC codes are to be billed with Revenue Code 3103.
- To initiate a face-to-face assessment for CBAS, fax the completed CBAS Treatment Request form to 1-855-556-7909. The CBAS Treatment Request form

is located at www.cahealthwellness.com > *For Providers > Provider Resources > Manuals, Forms and Resources*.

- Prior authorization or notification is required for CBAS services. Refer to the Prior Authorization Requirements section for additional information. For more information on how to submit a prior authorization request, use the following link (prior authorization request).
- Please use the following link: CBAS State guidelines reference.

Coordination of Benefits

- If the primary payer does not require prior authorization, prior authorization is not required for the secondary submission.
- If prior authorization is given by the primary payer, prior authorization is not required from California Health & Wellness Plan.
- Any time the POS does not report other insurance, the member and or subscriber must report this coverage to the local county office.
- If the service is not a covered benefit prior to service rendered, the MCO rules apply.
- If there is a primary payer, California Health & Wellness Plan must have a properly submitted claim along with the explanation from the primary payer (EOB/EOMB or denial). California Health & Wellness Plan will calculate the allowable amount under the plan, and subtract the amount paid. California Health & Wellness Plan will only pay non-duplicated benefits up to a maximum of the allowable amount under California Health & Wellness Plan or billed charges, whichever is less.

How to bill Medi-Cal after billing other health coverage

The provider must present acceptable forms of proof to California Health & Wellness Plan that all sources of payment have been exhausted, which may include:[1]

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

Prior authorization for out-of-network providers

Where a prior authorization is required, an out-of-network provider may leverage a letter of agreement (LOA) or similar mechanism. Without an LOA or similar agreement, the provider may be at risk for billed amounts exceeding the allowable FFS rate. [1]

Follow these guidelines to bill Medi-Cal after OHC:[2]

- Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.

- Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as payment in full.
- An EOB or denial letter from the OHC must accompany the Medi-Cal claim.
- The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any OHC payment. Refer to claim form completion instructions in the Medi-Cal provider manual for more information.
- When you bill, use Medi-Cal-approved HCPCS codes, CPT® codes and modifiers.
- Do not bill with HCPCS codes, CPT codes or modifiers where OHC paid, but which Medi-Cal does not recognize or allow.
- If services normally require a Treatment Authorization Request (TAR), the related procedures must be followed. Refer to the TAR Overview section of the Medi-Cal Other Health Coverage Provider Manual, Part 1, for details.

[1]Information taken or derived from *Medi-Cal Managed Care Enrollment and What this Means for Members and Providers* fact sheet. dhcs.ca.gov/services/Documents/MCQMD/OHC-and-MMCE-Fact-Sheet.pdf.

[2]Information taken or derived from Medi-Cal Provider Manual, Part 2. files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/othhlth.pdf.

CLIA Billing Instructions

Paper Claims

Complete Box 23 of a CMS-1500 form with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Note: An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form.

When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which

services were referred (unless one or more of the reference laboratories are separately billing).

When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Note: An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form.

When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing).

When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

DME/Supplies/Prosthetics and Orthotics

- Please use the following links to reference the appropriate frequency limits:
  - DME Billing Code Frequency Limits
  - Orthotics Billing Code Frequency Limits
- Please refer to the state DME Manuals for appropriate billing of modifiers
- Authorization is required for DME products exceeding the following threshold limits (cumulative cost of related items within a group): rental - $50; purchase - $100; and repair or maintenance - $250. This policy also applies to daily amounts that exceed the respective dollar limits for rental purchase, repair or maintenance for an individual item or combination of similar group DME items.
- For more information about DME, please use the following link: DME Billing.
- Authorization is additionally required for all orthotic codes when the cumulative costs for purchase, replacement or repair of orthotics exceeds $250 within 90-day period. This policy also applies to daily amounts that exceed $250 for an individual item or combination of items.
- For more information about Orthotics, please use the following link: Orthotic Billing.
- Modifiers should be used to identify rentals, repair, and purchases (new or used).
- Unlisted codes will not be accepted if valid HCPCS codes exist for the DME and/or supplies being billed.
- Use of miscellaneous codes, such as E1399, requires an invoice from the manufacturer.
  - The invoice must be from the manufacturer, not the office making a purchase
  - Catalog pages are not acceptable as a manufacturer's invoice.
- Some items are taxable:
  - When billing a code that is taxable, bill the code for the service with the appropriate modifier, less the sales tax.
  - The tax should be billed, per procedure code, using HCPCS code S9999 with charges only for the sales tax.
  - Tax billed on codes that are not taxable will be denied
- "Contracted" supplies require a valid HCPCS and accompanying UPN for each product dispensed

Drugs Administered by a Professional/Prescription Drugs/Infusion Therapy:

Drugs Administered by a Professional are classified as a medical benefit and are administered by a medical professional in an office setting.

- For information about authorization requirements, please use the Pre-Authorization Needed? Tool

Prescription drugs are a pharmacy benefit and are self-administered by the member. For self-administered prescription drugs, please see Chapter 5: Pharmacy Program.

- For additional information about whether a specific drug is on the Medi-Cal Rx Contract Drug List or requires prior authorization, please use the following link (Medi-Cal Rx Conract Drug List).

Infusion Therapy is a medical benefit and is administered by a home infusion therapy provider or are self-administered by the member.

- For information about authorization requirements, please use the Pre-Authorization Needed? Tool
- A valid NDC is required for all Enteral infusion products

EPSDT Family Planning

- Enter code "1" or "2" in BOX 24H – on the CMS 1500 claim form if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are EPSDT screening related. Leave blank if not applicable.
- For more information about EPSDT, please use the following link: Family Planning.

Code	Description
1	Family Planning/Sterilization (Sterilization *Consent Form* must be attached to the claim if code 1 is entered)
2	(Family Planning/Other
3	CHDP Screening Related

Refer to the *Family Planning* section of the appropriate Part 2 Manual for further details.

Home Health

- Must be billed on a UB 04
- Bill type must be 32X
- For more information about home health billing, including examples and billing codes, please refer to the following links (HH Billing Examples and HH Billing Codes)

Indian Health Service

Use the CMS-1450 (UB-04) form for all IHS Medi-Cal claims submitted to CHWP. Use the UB-04 with revenue codes and CPT/HCPCS codes. Revenue codes and CPT/HCPCS codes must be taken from the Indian Health Service – Memorandum of Agreement (IHS-MOA) Code Conversion Table found on the California Department of Health Care Services website.

For IHS claims submitted to specialty services vendors, use the forms indicated below:

- American Specialty Health, Inc. (acupuncture claims): CMS-1500
- Envolve Vision (vision services): CMS-1500
- MHN (behavioral health): UB-04

Locum Tenens/Reciprocal Billing

The practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as: illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though the regular physician performed them. These substitute physicians are generally called, "locum tenens" physicians.

Locum Tenens occurs when the substitute physician covers the regular physician during absences not to exceed a period of 90 continuous days.

Reciprocal Billing occurs when substitute physicians cover the regular physician during absences and or on an on-call basis not to exceed a period of 14 continuous days.

- The regular physician identifies the services as substitute physician services meeting the requirements of this section by appending the appropriate modifier:
  - **Q6 (**service furnished by a locum tenens physician) to the end of the procedure code,
  - **Q5** (service furnished by a substitute physician under a reciprocal billing arrangement) to the end of the procedure code.
- If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, those services should not be reported separately on the claim as substitution services.
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.

Mid-Level Provider Billing

Refer to Non-Physician Medical Practitioners Medi-Cal Manual to determine rendering physician and modifier billing requirements. Reimbursement for services rendered by a Non-Physician Medical Practitioner can be made only to the employing physician, organized outpatient clinic or hospital outpatient department. Payment is made at the lesser of the amount billed or 100 percent of the amount payable to a physician for the same service. No separate reimbursement is made for physician supervision of the Non-Physician Medical Practitioner.

The supervising physician's provider number must be entered as the rendering physician's on each applicable claim line. Do not identify the Non-Physician Medical Practitioner as the rendering provider on the claim line. Instead, include the Non-Physician Medical Practitioner name, provider number and type of Non-Physician Medical Practitioner in the Remarks field (Box 80)/Reserved for Local Use field (Box 19) of the claim.

- Physician Assistant
  - Modifier U7- Medicaid level of care, as defined by each state. Used by Medi-Cal to denote Physician Assistant services
- Nurse Practitioner
  - Modifier SA- Nurse Practitioner rendering service in collaboration with a physician Licensed Midwife
- Modifier U9 – Used when Licensed Midwife service is billed by a physician, hospital outpatient department or organized outpatient clinic
- Nurse Midwife
  - Modifier SB- Used when Certified Nurse Midwife service is billed by a physician, hospital outpatient department or organized outpatient clinic (not by CNM billing under his or her own provider number).

Modifiers

For more information on modifiers, please see Appendix VII: Approved, Discontinued and Invalid Modifiers or use the following link: Modifiers Listing.

- Billing Tip: Modifier KX should not be submitted in the first position,
- Billing Tip: Do not bill modifier 99

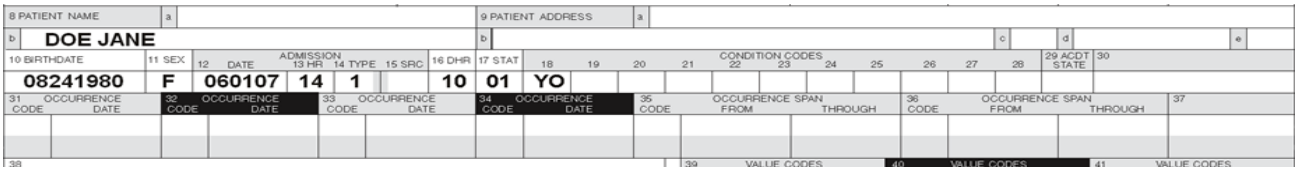
Mom/Newborn Billing

- Newborns of California Health & Wellness Plan members are covered under the mother, using the mother's member number, for the month of birth and the following month or until the Department of Health Care Services issues a member number to the newborn.

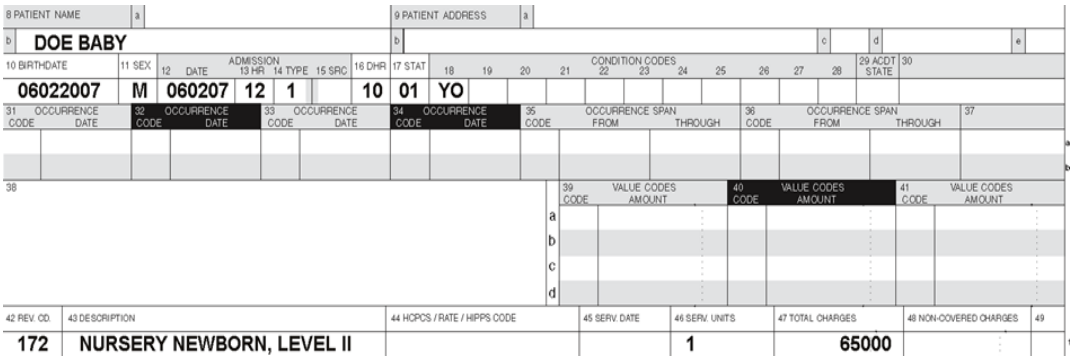
- Encourage California Health & Wellness Plan members to contact their social worker immediately and fill out all required paperwork to accurately enroll the newborn and prevent any lapse in coverage.

- Hospitals
    - When Filing Claim for Mother:
        - Must submit a claim for Mother and a claim for the Newborn separately. Do not submit Mother and Newborn on the same UB04 claim form.
        - Submit Mother's claim first. Notice of admission is required
        - Submit with Mother's ID, Mother's information, (i.e. DOB, sex), and delivery authorization.
        - For more information on how to submit a prior authorization request, use the following link (prior authorization request).
    - When Filing Claim for Newborn:
        - Submit Newborn's claim after Mother's claim has been submitted.
        - Healthy Newborn - submit with Mother's ID, Newborn's information, (i.e. DOB, sex) and delivery authorization.
        - Sick Newborn - submit with Mother's ID, Newborn's information (i.e. DOB, sex) and separate prior authorization required.
        - For more information on how to submit a prior authorization request, use the following link (prior authorization request).
    - When Filing Claim for Twin Newborns:
        - Submit each Newborn claim separately.
        - Healthy Newborn - submit with Mother's ID, Newborns' information, (i.e. DOB, sex) and delivery authorization.
        - Each Sick Newborn- submit with Mother's ID, Newborn's information (i.e. DOB, sex) and separate prior authorization required.
        - For more information on how to submit a prior authorization request, use the following link (prior authorization request).

MOTHER



BABY



Optional Benefits Exclusions

- Optional Benefit Exclusion billed services that are covered for members age 21 & over, require providers to bill modifiers TH, GY or KX. All providers are required to submit using these modifiers in such circumstances.

Pregnancy billing

- Global Billing – For more information about global billing for pregnancy services, use the following link (global billing).

- Per Visit Billing – For more information about billing per visit for pregnancy services, use the following link (per visit billing).

Pathology Billing

- For more information about billing for pathology services, please use the following link (pathology billing).

Podiatry Billing

- Please use the following link to obtain more information about podiatry billing (podiatry).

POA Indicator

- Present on Admission (POA) Indicator is required on all inpatient facility claims, unless the code is exempt from the POA reporting. Failure to include valid POA will result in a claim denial/rejection.
- The listing of Present on Admission Indicators is available on the California Health & Wellness Plan website Providers can access it by using this link: POA Indicators.

Vaccines

Refer to Immunization Medi-Cal Manual for more information. Use the following link: Immunization Manual. The VFC Program is an optional program. Providers are not required to participate. They can still purchase the vaccines themselves and be reimbursed at the Medi-Cal fee schedule amount rather than just the VFC administration rate.

- **SK Modifier** - Member of high-risk population (use only with codes for immunization)
- MMR CPT 90707
    - First dose is covered by California Health & Wellness Plan and should be billed WITHOUT Modifier SL. In addition, please include the notation “First MMR Dose” in Field 19 on the CMS 1500 form or Field 80 on the UB04 form.

CHAPTER 9: ENCOUNTERS

What is an Encounter?

An encounter is a claim that is paid at zero dollars, typically because the provider is pre-paid or receives a capitated payment for the services provided to California Health & Wellness Plan members. For example; if you are the PCP for a California Health & Wellness Plan member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided. Since you receive a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. **It is mandatory that your office submit encounter data.** California Health & Wellness Plan utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by the Department of Healthcare and Family Services (HFS) and by the Centers for Medicare & Medicaid Services (CMS). Encounters do not generate an Explanation of Payment (EOP).

Procedures for Filing a Claim/Encounter Data Electronically

California Health & Wellness Plan encourage all providers to file claims/encounters electronically. California Health & Wellness Plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, California Health & Wellness Plan has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

A single encounter is defined as all services performed by an individual provider on a given date of service for an individual member. The following guidelines are provided to assist providers with submission of complete encounter data:

- Reporting of services must be completed on a per member, per visit basis.
- Reporting of all services rendered by date must be submitted to California Health & Wellness Plan.
- Encounter data must reflect the same data elements required under the Medi-Cal fee-for-service program
- All encounter data reporting is subject to, and must be in full compliance with, the Health Insurance Portability and Accountability Act and any other regulatory reporting requirements.

Electronic encounter reporting is also subject to the following guidelines:

- Data must be submitted in the HIPAA compliant 837 format (ASC X12N 837).
- DHCS mandated values must be used when appropriate (e.g., procedure code modifiers).

- Electronic encounter data must be received no later than ninety (90) days from end of month following the encounter (e.g., by October 31st for all encounters occurring in July).
- Only encounter records that pass California Health & Wellness Plan edits will be included in the records evaluated for compliance. Encounters that fail these edits will be rejected and California Health & Wellness Plan will send error reports to the provider. If the failed encounter is corrected and resubmitted within the required timeframe it will be included in the calculation for performance standards. Please note that ONLY the corrected encounters need to be resubmitted.

See Chapter 8: Claims and Billing of this Manual for more information on how to initiate electronic claims/encounters. CHDP services will require a claim for payment to be submitted via paper submission directly to California Health & Wellness Plan. To obtain more information about how to submit electronic claims, please use the following link: electronic claims submission.

For more information on electronic filing, contact: California Health & Wellness Plan c/o Centene EDI Department (800) 225-2573, extension 6075525; or by e-mail at: EDIBA@centene.com.

Submitting Claims via Paper

You are required to submit either an encounter or a claim for each service that you render to a California Health & Wellness Plan member. For more information on how to submit a paper claim, please use the following link: paper claims submissions.

Billing the Member

California Health & Wellness Plan reimburses only services that are medically necessary and covered through the California Department of Health Care Services. In-network and out-of-network providers may not charge, or balance bill members for covered services.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not a covered benefit, or the member has exceeded the program limitations for a particular service **only** if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the client stating:

> ***I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under California Health & Wellness Plan as being reasonable and medically necessary for my care. I***

understand that California Health & Wellness Plan through its contract with the California Department of Health Care Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

CHAPTER 10: PRIMARY CARE PROVIDERS (PCP) AND OTHER PROVIDERS

The primary care provider (PCP) is the cornerstone of California Health & Wellness Plan's service delivery model. But while the PCP is the catalyst, all of our network providers - including Primary Care Providers (PCPs), Specialists and Ancillary Providers – play critical roles and are highly valuable in ensuring that our members receive the care they need, when they need it.

California Health & Wellness Plan actively partners with its providers, community organizations, and other groups serving its members to achieve this goal. It also achieves this goal through the meaningful use of health information technology (HIT). California Health & Wellness Plan supports primary care providers so that they may serve as the foundation for patient care. This support includes, but is not limited to, the development of systems, processes and information that promotes coordination of the services to the member outside of that provider's primary care practice.

From an information technology perspective, we offer several Health Information Technology applications for our network providers. Our secure **Provider Portal** offers tools that will help support providers in practicing primary care. These tools include:

- Online Care Gap Notification
- Member Panel Roster including member detail information
- TruCare Service Plan
- Health Record
- Provider Overview Report

Provider Responsibilities for All Contracted Providers

Panel Status Changes

Per California Health and Safety Code §1367.27, all providers must notify the plan of any changes in panel status within five (5) business days of the change occurring. For example, if the provider had a closed panel and is now ready to open their panel, that provider must notify California Health & Wellness Plan within five (5) business days.

If a provider is no longer accepting new patients and is contacted by a member, the provider shall:

- Direct the enrollee's or potential enrollee's to the Plan.
- Notify the Plan of inaccurate panel status data within 5 business days.

Demographic Changes

All providers should notify the plan of any demographic change in a timely fashion.

Providers may notify California Health & Wellness Plan of any panel and/or demographic changes using the following methods:

- Online: www.cahealthwellness.com under Provider Resources
- Email: CAProvData@cahealthwellness.com
- Phone: (877) 658-0305

Cooperation with Validation

Providers must cooperate with updating and/or verifying the provider information as requested or face potential penalties including delay of claims payments, capitation, removal from directories, or possible termination from the network.

Provider Types That May Serve As PCPs

Health Care professionals who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, nurse practitioners, certified nurse midwives and physician assistants. The PCP may practice in a solo or group setting or at a Federally Qualified Health Center "FQHC," Rural Health Center "RHC," Indian Health Center "IHC" or an outpatient clinic. California Health & Wellness Plan also permits a specialist to serve as a PCP for a member with multiple disabilities or with chronic conditions, if: (1) the specialist agrees in writing to serve as a PCP for the member; and (2) the specialist is willing to perform the responsibilities of a PCP as stipulated in this Provider Manual (see PCP Responsibilities).

Assignment of the Primary Care Provider

PCPs must see members who select them or are assigned to them by California Health & Wellness Plan. Not all members select a PCP when they enroll in California Health & Wellness Plan. As a result, our initial priority is to make certain that every member has a PCP. All California Health & Wellness Plan staff members who come in contact with members are trained on the PCP selection process and taught how to assist members who do not yet have an established relationship with a PCP. In the event that the enrollee does not select a PCP, we will auto-assign the enrollee to a PCP in our network. Pregnant members who do not have a PCP will receive a call from a Member Service Representative who will facilitate PCP selection within five business days of processing the enrollment file. Member Services Representatives will call all other members who have not selected a PCP and cannot be auto-assigned within 30 calendar days of enrollment to facilitate PCP selection.

Primary Care Medical Home

A. PCP Selection and Assignment

All Plan members have the opportunity to select a PCP or be assigned a PCP by the first day of enrollment. If a member does not choose a PCP, the Plan will assign the member to a PCP.

The PCP is responsible for rendering all standard primary care services to the member under the approve access to care guidelines. The Plan Provider Manual Section 10 specifies that members are always assigned to a unique PCP.

B. PCP Member Assignment Responsibility

PCPs are responsible to verify member eligibility and PCP assignment prior to rendering primary care services.

C. Changing Assigned PCP

If a member is not assigned to a PCP at the time service is requested and the member would like to switch to a different PCP, the member may request a PCP change by following one of the three methods indicated below.

1) Complete the member PCP change form found on http://www.cahealthwellness.com and fax it back to: 1-877-302-3434.

2) Call Plan's Member Services Department at 1-877-658-0305 (For TTY, contact California Relay by dialing 711 and provide them with 1-877-658-0305).

3) Submit change requests via the Plan's Web Portal www.cahealthwellness.com.

4) Members can request same day changes in order to accommodate urgent primary care needs.

D. Unassigned PCP Claims Denial

If the member is not assigned to the PCP on the date services are rendered and if the PCP chooses to render Primary Care services to a member not assigned to the PCP, the unassigned PCP's claim is subject to denial and in such instances, the PCP will not be eligible to bill the member for payment of the services rendered. Please see Section 1.B.

E. Redirection Of Members for Primary Care Services

If the member is not assigned to the PCP and is unwilling or refuses to change PCP assignment on the date services are rendered, the primary care office has the right to decline to render services to the member and redirect member back to the Plan for assistance or directly to the member's assigned PCP.

Continuity of Care

We recognize the importance of nurturing the patient primary care physician (PCP) relationship to establish care continuity for members. Some members may already have existing relationships with a provider prior to their enrollment with California Health & Wellness Plan (CHWP). CHWP supports continuation of previous or existing relationships between providers and members through its ongoing member outreach efforts. These outreach efforts start when we first receive notification of the member's enrollment with our plan and when we learn of an existing member-PCP relationship (such as through state claim data, member initiated contact, provider rosters, or similar means). If the pre-existing relationship is with a provider who is a contracted PCP, we link the member and provider in our eligibility system and generate an ID card that contains the assignment of the member to the PCP.

Requesting Continuity of Care

https://www.cahealthwellness.com/content/dam/centene/cahealthwellness/pdfs/COC Request Form_11.3.16 FNL.pdfCHWP accepts verbal and/or written continuity of care (COC) requests. New members, their authorized representatives on file with Medi-Cal or their providers may contact CHWP's
Medi-Cal Member Services Department to initiate the COC process. Providers may, but are not required to, complete the Continuity of Care Request form and submit to CHWP. The Continuity of Care Request form is located at www.cahealthwellness.com, under Manuals, Forms and Resources > Forms.

At a minimum, the following criteria must be satisfied for a COC request to be considered:

- COC is limited to a period of up to 12 months for Medi-Cal services if the member demonstrates an existing relationship with the nonparticipating provider prior to enrollment. CHWP verifies that the member has seen the nonparticipating PCP or specialty care provider at least once in the previous 12 months from the date of enrollment for a non-emergency visit.
- The provider meets applicable professional standards and does not have a record of any disqualifying quality of care issues that would make the provider ineligible to continue providing services to CHWP members.
- The provider is willing to continue treating the member and accepts payment from CHWP or the delegated entity based on the current Medi-Cal fee schedule, the higher of the plan's contracting rates or Medi-Cal fee-for-service (FFS) rates.
- The provider is a California State Plan approved provider.

- The provider supplies CHWP with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

COC is not available to members for services that are not covered by Medi-Cal. In addition, COC is not available for the following providers: durable medical equipment (DME), transportation, other ancillary services, and carved-out service providers.

Conditions Eligible for Continuity of Care

- Acute condition – a sudden onset of symptoms due to an illness, injury, or other medical problem.
- Serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder, not to exceed 12 months from the member's effective date of coverage.
- Pregnancy – for the duration of the pregnancy and the immediate postpartum period.
    - For members who provide written documentation of being diagnosed with a maternal mental health condition from the member's treating provider, completion of covered services will not exceed 12 months from the member's diagnosis or from the end of pregnancy, whichever occurs later.
    - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. Continuity of care applies for the duration for the terminal illness.
- Newborn care – birth to 36 months, not to exceed 12 months from the member's effective date of coverage under the plan.
- Surgery or a procedure scheduled by a provider that is authorized by the member's prior health plan as a documented course of treatment.
- Behavioral health conditions – all acute, serious or chronic mental health conditions, including treatment for children diagnosed with autism spectrum disorder (ASD). These services include applied behavioral analysis (ABA) – for up to 12 months.

Exceptions

Some of the circumstances where continuity of care is not available are:

- Services are not a covered benefit of the plan.
- Out-of-network provider does not agree to CHWP's utilization management policies and payment rates.
- CHWP has made good faith efforts to contact the provider and the provider has not responded to Health Net within 30 calendar days.
- A new member voluntarily chose to change health plans.
- A new member undergoing a course of treatment under an individual agreement with the provider on the effective date of coverage, unless the member's prior individual health plan was terminated by the health insurer. Self-attestation as proof of an individual agreement if not sufficient. The member must provide proof of a relationship and meet the other continuity of care requirements.
- Provider type or service is: durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

Continuity of Care Guidelines

- If a member changes Medi-Cal managed care plans, the COC period may start over one time.

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

Retroactive Requests

CHWP or the delegated entity must retroactively approve a COC request and reimburse providers for services that were already provided if the request meets all COC requirements described above and the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into CHWP.
- Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive COC reimbursement.

Retroactive COC reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

Validating Pre-existing Relationship

CHWP or the delegated entity determines if a relationship exists through use of data provided by the Department of Healthcare Services (DHCS). A member or his or her provider may also provide information to CHWP or the delegated entity that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided).

Following identification of a pre-existing relationship, CHWP or the delegated entity determines if the provider is an in-network provider. If the provider is not an in-network provider, CHWP or the delegated entity contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the member.

Request Completion Timeline

Each COC request must be completed within the following timelines:

- 30 calendar days from the date CHWP or the delegated entity received the request.
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs.
- Three calendar days if there is risk of harm to the member.

A request for COC is considered complete when:

- The member is informed of their right to continued access.

- CHWP or the delegated entity and the nonparticipating provider are unable to agree to a compensation rate.
- CHWP or the delegated entity has documented quality-of-care issues.
- CHWP or the delegated entity makes a good faith effort to contact the provider and the provider has not responded within 30 calendar days of the effort to contact the provider.
- CHWP or the delegated entity has recommended an in-network provider.

Upon approval of a COC request, CHWP or the delegated entity notifies the member of the following within seven calendar days:

- The request approval.
- The duration of the COC arrangement.
- The process that will occur to transition the member's care at the end of the COC period.
- The member's right to choose a different provider from CHWP's provider network.
    - At any time, CHWP members may change their providers regardless of whether a COC relationship has been established.

CHWP's Public Program Specialists (PPSs) are available to:

- Receive COC requests through inbound calls, fax, mail, or as part of the health risk assessment (HRA).
- Conduct and establish initial contact with the member. PPSs contact members by telephone to establish communication and assess unmet needs or risk of harm to the member.
- Review retroactive requests for COC that meet all the COC requirements.

Health Homes Program

COC with out-of-network providers is not available for Health Homes Program (HHP) services.

PPG/IPA Process

CHWP is responsible for implementing the COC review process within five days of receipt of the request. For delegated PPGs/IPAs, the PPSs forward the completed COC request determination to the PPG's/IPA's utilization management department for implementation of necessary authorizations that must be completed within 30 calendar days from CHWP's receipt of request for regular requests and 15 calendar days for more immediate cases. The PPG/IPA utilization management designee is responsible for issuing the authorizations, explaining the process for requesting continued services beyond the initial authorization and, if warranted, continuing out-of-network services up to the allowable continuation time frame (of 12 months). For requests of COC when there is potential risk of harm to the member, the PPS COC review process is completed within three days of the PPS's receipt of the request.

The PPS follows up with the out-of-network provider and member to confirm that they received authorization from the PPG/IPA, and both understand the process for further authorization requests until the end of 12 months for Medicare and Medi-Cal. The PPG/IPA case manager is responsible for working with the out-of-network provider to establish a care plan for the member. The PPG/IPA is responsible for notifying the member 30 calendar days prior to the end of the COC period about the transition to a new provider, and coordinates the transition with the out-of-network provider. The PPG/IPA works with the out-of-network provider to ensure they are willing to work with the PPG/IPA and CHWP. Out-of-network providers cannot refer the member to another out-of-network provider without authorization from CHWP or a delegated PPG/IPA.

For more information, please contact Member or Provider Services at 1-877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Primary Care Provider (PCP) Responsibilities

PCPs serve as the member's initial and most important contact. In addition to the Provider Responsibilities, PCP's responsibilities include, but are not limited, to the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all associated California Health & Wellness Plan members, or enter into an arrangement for management of inpatient hospital admissions of members.
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally responsive and timely manner while ensuring patient safety at all times, including members with disabilities and chronic conditions.
- Educate members on maintaining healthy lifestyles and preventing serious illness.
- Provide screenings, well care and referrals to community health departments and other agencies in accordance with the DHCS requirements and public health initiatives.
- Conduct a behavioral health screen based upon a provider assessment to determine whether the member requires behavioral health services or substance abuse services (such as alcohol misuse screening and counseling (AMSC)) and refer for services, if needed.
- Maintain continuity of each member's healthcare by coordinating care for the member.
- Offer hours of operation that are no less than the hours of operation offered to commercial and fee for service patients.
- Provide referrals for specialty and subspecialty care and other medically necessary services that the PCP does not provide.
- Facilitate follow-up and documentation of all referrals including to services available under the State's fee for service program.

- Collaborate with California Health & Wellness Plan's case management program as appropriate including, but not limited to, performing member screenings and assessments, developing a plan of care to address risks and medical needs, and linking members to other providers or support services (medical, residential, social and community) as needed.
- Maintain a current and complete medical record for the members in a confidential manner, including documentation of all services and referrals provided to the members, including, but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the CHDP periodicity schedule for members under 21 years of age.
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current "Pre-Auth Check" page on our website, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care.
- Share the results of identification and assessment for any member with special healthcare needs with another health plan to which a member may be transitioning, or has transitioned, so that those services are not duplicated.
- Actively participate in, and cooperate with, all California Health & Wellness Plan's quality initiatives and programs.
- Facilitate coordination with community mental health programs, including obtaining consent from members to release information regarding primary care.
- Perform the patient Initial Health Appointment (IHA) consisting of the patient's physical examination to assess the member's current acute, chronic and preventive health needs for each new member. An IHA should be completed within 120 calendar days following the date of enrollment. Use this link (IHA) for further information about the IHA, which is contained later in this chapter.

PCPs may have a formalized relationship with other PCPs to see their members when circumstances (e.g., vacation) dictate. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them, regardless of any additional PCP engagement. Furthermore, if a PCP has his/her members seen by another PCP, the other PCP must be contracted with California Health & Wellness Plan (or authorization is needed for a non-contracted PCP) and a locum tenens arrangement must be established.

Referrals

California Health & Wellness Plan prefers that the PCP coordinate members' healthcare services; however, PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of what the PCP can provide. ***Paper referrals are not required.*** The PCP must obtain prior authorization from California Health & Wellness Plan for referrals to certain specialty providers as noted on the "Pre-Auth Check" page on our website. **All out-of-**

network services require prior authorization. A provider is required to promptly notify California Health & Wellness Plan when a pregnancy is identified or prenatal care is rendered (see section on Notification of Pregnancy below). In accordance with state law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the providers' family has a financial relationship. For more information, use this link to review the section on Specialist Referrals in Chapter 7: Utilization Management.

Note: If you are part of an Independent Practice Association (IPA), please work with the IPA on the referral process.

Administration of Immunizations

Primary care physicians (PCPs) are responsible for immunizing members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize California Health & Wellness Plan members.

The Department of Health Care Services (DHCS) requires participating providers to document each member's need for Advisory Committee on Immunization Practices (ACIP)-recommended immunizations as part of all regular health visits and to report the administration of immunizations within 14 days.

PCPs must be available to administer immunizations during office hours. The PCP is responsible for updating the state-supplied "yellow card" (PM 298) immunization record or other immunization record.

At each visit, the PCP should inquire whether the patient has received immunizations from another provider. The PCP should also educate members regarding their responsibility to inform the PCP if they receive immunizations elsewhere (such as from an LHD or non-participating provider). This information is necessary for documentation and the member's safety.

VFC Immunization Program

All PCPs should make certain that appropriate immunizations are available for child members. Vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the federal Vaccines For Children (VFC) program. To participate, providers must enroll in VFC even if already enrolled with Medi-Cal or the Child Health and Disability Prevention (CHDP) Program.

To enroll in the VFC program or receive more information, providers should contact the Department of Health Care Services (DHCS) Immunization Branch by telephone at: (877) 243-8832, by fax at (877) 329-9832 or by writing to the following address:

VFC Program
Immunization Branch

Department of Health Care Services
850 Marina Bay Parkway, Building P
Richmond, CA 94804-6403

California Health & Wellness Plan will reimburse an administration fee per dose to providers who administer the free vaccine to eligible members through the VFC program or other sources. Please refer to Chapter 8: Billing and Claims Submission for instructions on how to submit claims (or use the following link: vaccines).

Additionally, California Health & Wellness Plan encourages providers to participate in the California Immunization Registry (http://cairweb.org/) a statewide entity. Imperial County providers are encouraged to participate in the Imperial County Public Health Information Management System, an immunization registry that serves Imperial County. Immunization registries are important tools for improving rates of vaccination across the state, and active use of these tools by California Health & Wellness Plan providers supports accurate documentation of HEDIS measures for the plan.

Medi-Cal Medical Record Documentation Standards

Medi-Cal providers are required to meet both California Health & Wellness Plan and the Department of Health Care Services (DHCS) Medi-Cal medical record documentation standards. The following documentation guidelines must be followed and all of the elements must be included in the medical records of Medi-Cal members.

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing impaired persons, individual personal biographical information, emergency contact, and identification of the member's assigned primary care physician (PCP).
- The refusal or request of interpreter services by an LEP-speaking health plan member must be documented in the medical record. Providers are required to document in the medical record the refusal of qualified interpreter services and the preference of a health plan member to use a family, friend or minor as an interpreter.
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the ofference of advanced health care directive information and education to members 18 and older must be included.
    - Telephone advice - notation of the date of the call, time, details of the conversation, and signature and title of the staff member handling the call
    - Urgent and emergency documentation - notation of the date, time, means of arrival, history of illness or accident, physical findings, diagnostic tests, treatment received, diagnostic impression, and discharge summaries

- Coordination of care - Notation of missed appointments, follow-up care and outreach efforts, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans
- Preventive care - All new Medi-Cal members must receive an Initial Health Appointment (IHA), which includes an age-appropriate history and physical examination within 120 days of enrollment.
    - Members may be seen initially during a visit for episodic care. Regardless of the reason for the initial visit, the provider within the primary care setting or PCP should conduct the IHA at the first health care contact and document the assessment in the medical record.
- Adult preventive care and anticipatory guidance, according to the United States Preventive Services Task Force (USPSTF) - Notation of periodic health evaluations, assessment of immunization status and the year of the immunization(s), tuberculosis screenings and testing, blood pressure and cholesterol screenings, Chlamydia screenings for sexually active females to age 25 or at risk, and mammograms and Pap tests for females. Pediatric preventive care and anticipatory guidance, according to the AAP - Notation of age-appropriate physical exams; immunizations specified and within AAP and Healthcare Effectiveness Data and Information Set (HEDIS®) requirements; anticipatory guidance for age-appropriate levels; vision, hearing, lead, and tuberculosis screenings and testing; and nutrition and dental assessments.
- DHCS requires 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.
- Perinatal preventive care - notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, including a timely prenatal visit within the first trimester; initial and subsequent comprehensive prenatal assessments (ICA) and trimester reassessments; postpartum visit four to six weeks after delivery - this interval may be modified according to the needs of the member, such as HEDIS timelines of 21-56 days after delivery; individualized care plan (ICP); domestic violence and abuse screenings; human immunodeficiency virus (HIV), alpha fetoprotein (AFP), and genetic screenings; Women, Infants, and Children (WIC) referrals; and assessments of infant feeding status.

Notifications of Pregnancy

The managing or identifying Physician, Certified Nurse Midwife, or Certified Nurse should notify the California Health & Wellness Plan prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit or confirmation of pregnancy (use this link to access the Notification of Pregnancy Form). Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services. Providers are expected to identify the estimated date of confinement and delivery facility. See the Chapter 12: Case Management for information related to our Start Smart for Your Baby® program and our High Risk Pregnancy program for women with a history of early delivery.

Primary care physicians only should complete the Confirmation of Pregnancy Form and fax it to the number at the top of the form.

Certified Nurse Midwives and Licensed Midwives

Medi-Cal members have the right to receive covered nurse midwife services from any Medi-Cal freestanding birth centers (FBCs) and to services provided by certified nurse midwives (CNMs) and licensed midwives (LMs) without referral or prior authorization.

Services provided by Medi-Cal participating FBCs, CNMs and LMs are a covered benefit. However, services or treatments that are specifically excluded from Medi-Cal coverage are not covered.

The Department of Health Care Services (DHCS) authorizes CNMs and LMs as providers of all services permitted within the scope of the practitioner's license. Both are authorized under state law to provide prenatal, intrapartum and postpartum care. This includes family planning care for the mother and immediate care for the newborn.

The table below outlines the differences between these two provider types and conditions under which they can provide care.

Midwife type	Licensing	Services
CNM	Licensed as a **registered nurse** and certified as a nurse midwife by the *California Board of Registered Nursing.*	Permitted to "attend cases of normal childbirth"
LM	Licensed as a **midwife** by the Medical Board of California.	Permitted to "attend cases of normal pregnancy and childbirth, as defined" and must adhere to a detailed set of restrictions and requirements when a patient's condition deviates from the legal definition of normal.

Doula Services

APL 22-031, effective January 1, 2023, states a physician or other licensed practitioner must recommend doula services to an eligible Medi-Cal member. The physician or licensed practitioner that provides the recommendation does not need to be enrolled in Medi-Cal or be in-network.

Doula services **are** considered preventive and offer support before, during and after childbirth. Doulas **do not** diagnose medical conditions, provide medical advice, or clinical assessment, exam, or procedure.

Eligibility requirements

The member must be active and enrolled in the Medi-Cal Plan.

- Doulas must verify eligibility for the month of service by contacting the Plan.
- The member must be pregnant or have been pregnant within the past year and would benefit from doula services or requested doula services.

Documentation requirements

Initial recommendation – the physician or licensed practitioner can use one of the following methods:

- Member's record – written recommendation added.
- Standing order for doula services.
- A signed standard form that the member can give to the doula.

Second recommendation – Additional visits during the postpartum period require a second recommendation:

- Up to nine postpartum visits can be added.
- Cannot be established by a standing order for doula services.

Initial recommendation coverage

Members can receive doula services virtually or in-person in any setting, such as home, office, hospital, or an alternative birthing center. All visits are limited to one per day, per member.

The initial recommendation authorizes the following:

- One initial visit.
- Additional visits – up to eight given in any combination of prenatal and postpartum visits.
- Labor and delivery support – including miscarriage, stillbirth and abortion.
- Postpartum – up to two extended three-hour visits. These visits do not require the member to meet any criteria or receive a separate recommendation.

Assistive services during visits

Doulas can also give assistive or supportive services during an in-home prenatal or postpartum visit. This support provides face-to-face interaction while helping with emotional or educational support, such as folding laundry or drying dishes with the pregnant member. An assistive or supportive activity with the member cannot be billed to the member.

Coordinating services

Doulas should work with the member's primary care physician (PCP) or contact the Plan to refer a member to a network provider for the following services:

- Behavioral health services.
- Belly binding after cesarean section by clinical personnel
- Clinical case coordination.
- Health care services related to pregnancy, birth, and the postpartum period.
- Childbirth education group classes.
- Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services).
- Hypnotherapy (non-specialty mental health service).
- Lactation consulting, group classes, and supplies.
- Nutrition services (assessment, counseling, and development of care plan).
- Transportation.
- Medically appropriate Community Supports services.

If a doula teaches classes, the classes can be offered at no cost to a member receiving services from the doula.

Non-covered doula services

The following are not covered under doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Dyadic Services

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 and parent(s)/caregiver(s) together, preferably within the pediatric primary care setting the same day as the medical well-child visit. Dyadic services screen for behavioral health problems, interpersonal safety, tobacco and substance misuse and social drivers of health (SDOH), such as food insecurity and housing instability, and include referrals for appropriate follow-up care.

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

Referral to MHN

Primary care physicians (PCPs) or sites that do not offer behavioral health services can initiate dyadic services by conducting the medical well-child visit and referring members to MHN to

connect with a dyadic services provider who will conduct the DBH well-child visit and determine needs for ongoing dyadic services

Claims submission

Provider sites with integrated physical health and behavioral health services, such as Community Health Centers, FQHCs, and some primary care sites, will be able to administer the medical well-child visit, the DBH well-child visit and some or all of the additional dyadic services (depending on scope of practice). In such cases, integrated provider sites will bill the Plan for the medical well-child visit, and bill MHN for the dyadic service(s).

Street Medicine Services

California Health & Wellness Plan covers street medicine for Medi-Cal members experiencing unsheltered homelessness. The street medicine benefit covers up to the full array of services necessary to meet immediate needs, including but not limited to, preventive services, and the treatment of acute and chronic conditions.

Member eligibility verification

Providers are responsible for verifying benefits and member eligibility each time a member is scheduled to receive services.

Check eligibility through either of the following:

- The provider portal (preferred method).
- The Automated Eligibility Verification System (AEVS).

Coordinating services

Street medicine providers are responsible for coordinating member care with the member's primary care physician (PCP) and/or independent practice association (IPA) and initiating specialist referrals, including behavioral health, Community Supports and social services, when needed.

Claims billing

Claims are paid based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Providers may bill Place of Service (POS) codes to Fee-for-Service Medi-Cal or the Plan when rendering medical services for street medicine. For more information on billing for street medicine refer to the Department of Health Care Services (DHCS) billing guidelines.

Freestanding Birth Centers

Federal law mandates coverage of freestanding birth centers (FBCs), also referred to as alternative birthing centers (ABCs), services and requires separate payments to providers administering prenatal labor and delivery or postpartum care. FBCs or ABCs are specialty clinics authorized to bill Medi-Cal for Comprehensive Perinatal Services Program (CPSP), obstetrical and delivery services. These centers must be accredited and certified with either the Commission

for the Accreditation of Birthing Centers (CABC) or CPSP to provide prenatal labor and delivery, or postpartum care and other ambulatory services that are included in the plan coverage.

Primary care physicians (PCPs) may help members in obtaining FBC, ABC, CNM, and LM services by accessing the American College of Nurse Midwives' Find a Midwife website at www.midwife.org, and entering the member's geographic information. Members who do not have Internet access, or need translation services or other assistance, may call California Health & Wellness Plan.

Specialist Responsibilities

California Health & Wellness Plan encourages specialists to communicate with the PCP if there is a need to make a referral to another specialist, rather than making such a referral themselves. This allows the PCP to be aware of the additional service request, and to better coordinate the member's care. It also will help make certain that the referred specialty physician is a participating provider within the California Health & Wellness Plan network. The specialty physician may order diagnostic tests without PCP involvement by following California Health & Wellness Plan's referral guidelines.

Emergency admissions require notification to California Health & Wellness Plan's Medical Management Department within one day of admission to conduct medical necessity review. All non-emergency inpatient admissions require prior authorization from California Health & Wellness Plan's Medical Management Department.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from California Health & Wellness Plan's Medical Management Department (Medical Management) if needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for, or provide, on-call coverage through another source 24 hours a day for management of member care
- Maintain the confidentiality of medical information
- Actively participate in, and cooperate with, all California Health & Wellness Plan quality initiatives and programs

California Health & Wellness Plan providers should refer to their contract for complete information regarding provider obligations and mode of reimbursement, or contact their Provider Network Specialist with any questions or concerns.

Hospital Responsibilities

California Health & Wellness Plan utilizes a network of hospitals to provide inpatient and other hospital-based services to California Health & Wellness Plan members. Hospital service

providers must be qualified to provide services under the California Medi-Cal program. Hospitals must be credentialed by California Health & Wellness Plan to provide services under contract to our members. Please see Chapter 14 of this Manual for more information about the credentialing process. All services must be provided in accordance with applicable state and federal laws and regulations.

Hospitals must:

- Obtain authorizations for all inpatient and selected outpatient services as listed on the current "Pre-Auth Check" page on our website, except for emergency stabilization services.
- Notify California Health & Wellness Plan's Medical Management Department of all admissions within one business day.
- Notify California Health & Wellness Plan's Medical Management Department of all specialty care nursing admits within one business day of admission.

California Health & Wellness Plan's Medical Management Department can be notified of the admission by faxing the Face Sheet to 855-556-7907 or by calling 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). Arrangements to submit an electronic admission file can be made by contacting the Medical Management Department at 877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Facility Decertification Notification Requirement

California Health & Wellness Plan is required to end contracts with network providers and subcontractors who have been decertified or whose participation has been revoked from the Medi-Cal and Medicare programs.

The California Department of Public Health (CDPH) is responsible for decertifying licensed long-term care (LTC) facilities. LTC facilities that receive a decertification notice from CDPH must take these steps:

1) Notify their California Health & Wellness Plan Provider Network Management representative to begin the contract termination process.
2) Help with the transition planning for California Health & Wellness Plan members in the LTC facility's care.

Affected LTC facilities

These requirements apply to any of these LTC facility types:

- Skilled nursing (SNFs).
- Intermediate care.
- Nursing.
- Pediatric day.
- Respite.

California Health & Wellness Plan's responsibilities

Upon notice from the LTC facility, California Health & Wellness Plan:

- Ends its contract with the LTC facility within five business days of the notice.
- Develops and submits a member transition plan to the DHCS.
- Suspends all payments for services provided after the effective date of the decertification notice.
- Informs all affected contracted providers and members of the decertified LTC facility.
- Coordinates care for members as required by federal and state law, and California Health & Wellness Plan's contract with DHCS.

Immediate closure of LTC facilities by CDPH

In these cases, CDPH handles the transition of all affected members residing in the LTC facility. California Health & Wellness Plan tracks the transition of members and coordinates care as needed.

Accessibility Standards and Expectations

This section contains California Health & Wellness Plan's key expectations and standards regarding provider accessibility. These expectations and standards help our members obtain appointments and receive services within specific timeframes.

Initial Health Appointment

For each new member, PCPs or other providers within the primary care setting must perform an Initial Health Appointment (IHA). The IHA includes a complete physical examination to assess the member's current acute, chronic and preventive health needs, a full medical history, and an assessment of health behaviors. The IHA includes:

- Dental screening and oral assessment for children ages 3 and under, including referral to dental provider if needed (PCP performs assessment and refers the member to the dentist);
- Immunizations, including documentation of all age-appropriate immunizations in the member's medical record; and
- Screening for tuberculosis.
- Screening for behavioral risk, including tobacco and alcohol use for patients 18 and older (PCP administers the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test—Consumption (AUDIT-C) when patient answers positive on alcohol screening question).

PCPs or other providers within the primary care setting should provide new members with an IHA within 120 days of the date of enrollment. As part of the IHA requirements, preventive care services should follow the American Academy of Pediatrics Bright Futures and the U.S. Preventive Services Task Force clinical and preventative guidelines.

Based on the member's behavioral risks and willingness to make lifestyle changes, the PCP or provider within the primary care setting should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP or provider within the primary care setting and the member should develop a mutually agreed-upon risk reduction plan.

Childhood Blood Lead Screening

Providers must follow the Department of Public Health and the California Childhood Lead Poisoning Prevention Branch (CLPPB)-issued guidelines on childhood blood lead screening, which includes CDC Recommendations for Post-Arrival Lead Screening of Refugees, and also:

- Provide oral or written guidance to the parents or guardians of a child that includes information that children can be harmed by exposure to lead. The guidance must be provided at each periodic health assessment for ages 6–72 months.
- Perform blood lead level (BLL) testing on all children as follows:
  - At ages 12 months and 24 months.
  - When the provider performing the periodic health assessment becomes aware that a child age 12–24 months has no documented evidence of a BLL test taken at age 12 months or thereafter.
  - When the provider becomes aware that a child age 24–72 months has no documented evidence of BLL test results taken at age 24 months or thereafter.
  - Whenever the provider becomes aware that a child age 12–72 months has had a change in circumstances that places the child at increased risk of lead poisoning, in the provider's professional judgement.
  - When requested by the parent or guardian.
- The health care provider is not required to perform BLL testing in the following cases. The reasons for not screening must be documented in the child's medical record.
  - The parent or guardian refuses consent for the screening. 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.).
  - If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.

Blood lead level screening must be reported.

- Encounter or claims data is used to track the administration of blood level screenings. Providers must ensure that encounters/claims are accurately identified using the appropriate CPT codes for blood lead level screening.

Laboratories and health care providers performing blood lead analysis on specimens are to electronically report all results to CLPPB, with specified patient demographics, ordering physician and analysis data on each test performed. Information on how to report results to CLPPB can be found on the California Department of Public Health website.

Primary Care Travel Time and Distance Standards

California Health & Wellness Plan offers a robust network of primary care providers so that every member has access to primary care within the required time and travel distance standards:

- **Within 10 miles or 30 minutes**

California Health & Wellness Plan requests that PCP's inform our Member Services Department ("Member Services") when a California Health & Wellness Plan member misses an appointment, so we may monitor and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of emergency room services.

Member Panel Capacity

All PCPs may reserve the right to state the number of members they are willing to accept into their panel. California Health & Wellness Plan DOES **NOT** guarantee that any provider will receive a certain number of members.

The provider to member ratio shall not exceed the following:

- Primary Care Providers– 1: 2,000
- Physicians – 1: 1,200
- Non-Physician Medical Practitioners – 1: 1,000

Physician Supervisor to Non-Physician Medical Practitioner ratio shall not exceed the following:

- Nurse Practitioner 1:4
- Physician Assistants 1:4
- Four Non-Physician Medical Practitioners in any combination that does not include more than three Certified Nurse Midwives or two Physician Assistants

The panel capacity for Federally Qualified Health Centers is based upon standards established by the Health Resources and Services Administration.

If a PCP desires a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact California Health & Wellness Plan Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). **A PCP shall not refuse to treat members as long as the physician has not reached his or her requested panel size.**

Providers must notify California Health & Wellness Plan in writing at least 45 days in advance of his or her inability to accept additional Medi-Cal covered persons under California Health & Wellness Plan agreements. In no event shall any established patient who becomes a covered person be considered a new patient. California Health & Wellness Plan prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medi-Cal members.

Appointment Accessibility Standards

California Health & Wellness Plan has a documented system that monitors and evaluates practitioner/provider availability and members' access to care.

- At least annually, appointment access and provider availability standards are monitored through member and provider surveys.
- At least quarterly, information is reviewed and evaluated for accessibility, availability and continuity of care obtained from appeals and grievances, triage or screening services, and customer service telephone access. The review measures performance, confirms compliance and ensures the provider that California Health & Wellness Plan provides appropriate accessibility, availability and continuity of care to members.

Independent Practice Associations (IPAs) receive data from California Health & Wellness Plan about their adherence to appointment access standards which should be reviewed and monitored. If established standards are not met, IPAs may receive corrective actions. Refer to the Corrective Action section below for further information.

California Health & Wellness Plan's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

California Health & Wellness Plan Medi-Cal Plans Medical Appointment Access Standards

Reminder: Providers must ensure interpreter services are available at the time of the appointment.

Appointment Type	Appointment Standard	Performance Goal
PCPs and Specialists		
Urgent care appointments with primary care physicians (PCPs) that do not require prior authorization	Appointment within 48 hours of request	80%
Urgent care services with specialist (SCP) and other that requires prior authorization	Appointment within 96 hours of request	80%
Non-urgent appointments with PCP – regular and routine care	Appointment within 10 business days of request	80%
Non-urgent appointment with specialist (SCP)	Appointment within 15 business days of request	80%
Preventive health, physical exams and wellness check checks with PCP	Appointment within 30 calendar days of request	80%
First prenatal visit with PCP	Appointment within 2 weeks of request	80%
Well-child visit	Appointment within 10 business days of request	80%
Wait Time, Call Back and After-Hours Care		
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	80%
Provider office telephone callback during normal business hours	Provider callback within one business day	80%
Telephone answer time at provider's office	Within 60 seconds	80%

After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Ancillary Services		
Access to non-urgent ancillary services for magnetic resonance imaging (MRI), mammogram, physical therapy	Appointment within 15 business days of request	80%
Skilled Nursing		
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Rural and Small Counties: Within 14 calendar days of request Medium Counties: Within 7 business days of request Large Counties: Within 5 business days of request	80%

* *In the event of a non-life-threatening emergency, practitioners are also expected to refer members to an emergency department or a crisis center if the practitioner cannot see the member within six hours.*

Surveys are conducted via phone, fax or email. Telephone access surveys are not part of the Provider Appointment Availability Survey (PAAS) or the Provider After-Hours Availability Surveys (PAHAS), which are conducted separately via telephone. Telephone Access surveys are part of the non-DMHC Provider Appointment Availability Survey (non-DMHC PAAS).

Corrective Action

California Health & Wellness Plan investigates and implements corrective action when timely access to care is not met, as required by California Health & Wellness Plan's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.38).

The following criteria is used to identify IPAs with patterns of noncompliance. A corrective action plan (CAP) is issued when one or more of the metrics below are non-compliant:

- Appointment Access - 80% rate of compliance/performance goal in one or more of the appointment access metrics.

- After-Hours Access - 90% rate of compliance with one or more of the after-hours metrics.

IPA Notification of CAP

California Health & Wellness Plan provides the following to IPAs:

- Description of the identified deficiencies, rationale for the corrective action and contact information of the person authorized to respond to provider concerns regarding the corrective action.
- Feedback about the accessibility of primary care, specialty care and telephone services, as necessary.

CAP Minimum Requirements

- IPAs identified with additional non-compliance on one or more timely access and/or after-hours access metrics are required to submit a written Improvement Plan (IP), documenting specific interventions that will be implemented to improve the access availability. The written IP must include:
    - Target date for completion of implementation of action plan.
    - Department/person responsible for the implementation and follow-up of the action plan.
    - Anticipated date that the action plan is expected to produce outcomes that result in the standard meeting regulatory agency timeframe compliance.
    - The IPA is to return the action plan within 30 calendar days of the CAP distribution date.

CAP Follow-Up Process

- If the IPA fails to acknowledge receipt of the Corrective Action Plan, the issue will be escalated to Provider Network Management.
- If the IPA fails to return a completed IP within 30 calendar days, the Provider California & Wellness work Management (PNM) Department is asked to intercede.
- IPAs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to the PNM and Contracting departments for further action.

Provider Online Training

Providers deemed non-compliant will need to attend an online Provider Training session as part of the CAP process. California Health & Wellness Plan will notify all non-compliant providers of the training schedule. The IPA must sign up for at least one session. Attendance at the training will be documented as completed CAP in the IPA/provider IP.

CAP Process for Direct Network and MHN Services

California Health & Wellness Plan implements Plan-level corrective actions for its direct network providers. Provider Educational CAP packets are sent to all non-compliant providers. The packets are sent as notification to the provider for non-compliant measures and providing educational resources.

Provider Educational CAP packets includes the following material:

- Provider Educational CAP Letter
- Noncompliance Measure Summary
- Patient Experience Toolkit

For Behavioral Health services, refer to the following MHN P&Ps: MHN QI Monitoring Access to Care and MHN UM Urgent & Emergent Access.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another California Health & Wellness Plan network provider. In the event of unscheduled time off, please notify Provider Services of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and if the covering provider is not a California Health & Wellness Plan network provider, he/she will be paid as a non-participating provider.

24-Hour Access

California Health & Wellness Plan's PCPs and specialty physicians are required to maintain sufficient access to covered physician services so that such services are accessible to members as needed, 24 hours a day, seven days a week.

Note: **If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to members receiving urgent or emergent care.**

California Health & Wellness Plan will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program ("QIP").

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered after hours by a recording that tells patients to leave a message.
- The provider's office telephone is answered after hours by a recording that directs patients to go to an emergency room for any services needed.
- After-hours calls are returned after thirty minutes.

- The provider’s office hangs up on calls from a relay operator or communications assistant.

The selected method of 24-hour coverage chosen by the provider must connect the member or caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialty physician or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office’s daytime telephone number.

Appointment Rescheduling

According to timely access regulations (T28 CCR 1300.67.2.2) and California Health & Wellness Plan’s Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly; in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care and be consistent with good professional practice and with the objectives of California Health & Wellness Plan’s access and availability policies and procedures.

Telephone/Relay Arrangements

PCPs and Specialists must:

- Answer the member's telephone/relay inquiries on a timely basis appropriate for the member's condition.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule broken and no-show appointments.
- Identify cultural, linguistic, or disability access needs while scheduling an appointment for a member (e.g. wheelchair access, interpretation, translation, or modification of policies and procedures for people with mental health, intellectual or developmental disabilities).
- Adhere to the following response time for telephone call-back waiting times for afterhours telephone care for non-emergent, symptomatic issues within
    - 30 minutes
    - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- Document after-hour calls in a written format in either an after-hour call log or some other method, and then transfer the information to the member's medical record.
- Provide for a system or service to address calls made after office hours.
- During after-hours, a provider must have arrangement for:
    - Access to a covering physician
    - An answering service
    - Triage service or a voice message that provides a second phone number that is answered
    - Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members
- If the provider office uses non-licensed staff to triage and manage phone calls, the non-licensed staff shall not use the member's answers to assess, evaluate, advise or make decisions regarding the member's access to care.

Cultural, Linguistic and Disability Access Services

To request cultural, linguistic and disability access services, contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) for assistance.

Providers must provide or cooperate with California Health & Wellness Plan's arrangement for the provision of:

- 24-hour interpretation services in all languages (including American Sign Language) at all key points of contact for members accessing routine, urgent, and emergency health care services either through trained and competent face-to-face interpreters, signers, or bilingual providers and provider staff, telephone or Telecommunications Relay language services, or any electronic options the plan and provider choose to utilize, in a manner that is appropriate for the situation in which language assistance is needed;
- Fully translated written-informing materials in threshold languages, in other languages through oral interpretation upon request, and in alternative formats upon request;
- Referrals to culturally and linguistically appropriate community service programs; and
- Auxiliary aids and services, and modifications of policies, practices, and procedures for members with disabilities within a reasonable time frame appropriate for the situation (including, but not limited to: assistive listening devices, real-time captioning, and audio recordings).

For the purposes of this section, "key points of contact" are both medical and non-medical settings and include, but are not limited to: telephone, advice, urgent care transactions, outpatient encounters with providers including pharmacists, and appointment scheduling. Providers must inform members of the availability of these services, facilitate access to these services, and document in the member's medical record any offer of services, as well as any instance in which such offer is declined. Providers must also provide any information necessary to assess compliance; require bilingual providers and/or office staff to complete and American Sign Language capability disclosure forms; and provide quarterly updates on any changes in disability access and/or the language capabilities of staff for the Provider Directory by submitting new language capability disclosure forms.

Inclusion

California Health & Wellness Plan considers inclusion of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a California Health & Wellness Plan member a covered services or availability of a facility;

- Providing a California Health & Wellness Plan member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: different waiting rooms or appointment times or days); and
- Subjecting a California Health & Wellness Plan member to segregation or separate treatment in any manner related to covered services.

Marketing Requirements

We recognize that providers may want to engage in marketing activities to promote their practice or facility. However, there are specific guidelines regarding marketing to California Health & Wellness Plan members that must be followed. All marketing materials utilized by California Health & Wellness Plan must be approved by Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) prior to distribution to members. Additionally:

- Neither California Health & Wellness Plan nor its contracted providers can offer anything of value as an inducement to enrollment, including the sale of other insurance to attempt to influence enrollment.
- Neither California Health & Wellness Plan nor its contracted providers can directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment or for any other purpose.
- California Health & Wellness Plan or its contracted providers cannot make any written or oral statements in marketing materials that a potential member must enroll with California Health & Wellness Plan in order to obtain benefits or not retain existing benefits.
- California Health & Wellness Plan cannot make any assertion or statement in marketing materials that it is endorsed by CMS, the Federal or State government or similar entity.
- California Health & Wellness Plan cannot conduct marketing presentations at primary care sites.

Providers should not create and distribute any marketing materials to California Health & Wellness Plan members without prior approval by California Health & Wellness Plan, the DHCS and the DMHC. Should you have any questions regarding these marketing requirements, please feel free to contact Provider Services or your Provider Network Specialist.

Voluntarily Leaving the Network

Providers must furnish California Health & Wellness Plan a notice of voluntary termination following the termination of their participating agreement with the health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request, and facilitate the member's transfer of care at no charge to California Health & Wellness Plan or the member.

California Health & Wellness Plan notifies affected members in writing of a provider termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. If the terminating provider is a PCP, California Health & Wellness Plan will request that the member elect a new PCP within 15 business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, California Health & Wellness Plan will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until California Health & Wellness Plan can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, California Health & Wellness Plan reimburses the provider for the provision of covered services for a period of up to 90 days from the provider's termination date. In addition, California Health & Wellness Plan reimburses providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery. Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from California Health & Wellness Plan

California Health & Wellness Plan provides written notice to a member within seven days, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

Member Notification for Specialist Termination

Independent physician associations (IPAs) must have a written policy regarding member notification when a specialist terminates their contract. The written policy must include the following elements:

- IPAs must notify California Health & Wellness Plan 90 days prior to a specialist terminating (or as stated in the IPAs Provider Participation Agreement (PPA)).
- IPAs must identify members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist.
- Identified members must be notified by the IPA in writing and the notification must be made immediately upon notification of termination, but no later than 30 calendar days prior to the effective date of the specialist's termination.

- IPAs must help members transition to a new specialist within the IPA's network of participating providers.

If a member with an acute care condition has questions or concerns regarding the continuation of services from the terminating specialist, advise the member to call California Health & Wellness Plan's Customer Contact Center at 1-877-658-0305.

CHAPTER 11: HEALTH SERVICE PROGRAMS

24-Hour Nurse Advice Line

Our members often have many questions about their health, their primary care provider, and/or access to emergency care. California Health & Wellness Plan offers a 24-hour, seven day per week nurse advice line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care.

Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the service. Our staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use the 24-hour Nurse Advice Line to request information about providers and services available in the community after hours, when the California Health & Wellness Plan, Member Services Department ("Member Services") is closed. Our staff is available to talk with you in both English and Spanish and can provide additional interpretation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or our 24-Hour Nurse Advice Line at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Child Health and Disability Prevention (CHDP) Program

The Child Health & Disability Prevention Program (CHDP) is Medi-Cal's comprehensive and preventive child health program for individuals under the age of 21 (ages 0 through their 20th year and 11 months) to receive periodic health screening exams required by Federal Medicaid Early and Periodic Screening mandates in California. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the Medi-Cal plan to the rest of the Medi-Cal population.

California Health & Wellness Plan and its providers furnish the full range of CHDP services as defined in, and in accordance with, California state regulations and California Department of Health Care Services' policies and procedures for Early and Periodic screening services. Such services include, without limitation, periodic health screenings and appropriate up-to-date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for

pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are included in the periodic health screening assessment:

- Comprehensive health and developmental history (including assessment of both physical and mental development);
- Comprehensive unclothed physical examination;
- Appropriate behavioral health and substance abuse screening;
- Immunizations appropriate to age and health history;
- Laboratory tests;
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses;
- Dental screening and services;
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and
- Health education, counseling and anticipatory guidance based on age and health history.

Provision of all components of the CHDP service must be clearly documented in the PCP's medical record for each member.

California Health & Wellness Plan requires that providers cooperate to the maximum extent possible with efforts to improve the health status of California citizens, and actively participates in the effort to increase of percentage of eligible members obtaining CHDP services in accordance with the adopted periodicity schedules. California Health & Wellness Plan cooperates and assists providers in identifying and immunizing all members whose medical records do not indicate up-to-date immunizations.

Providers are strongly encouraged to participate in the California Vaccine for Children (VFC) Program. For information about this program visit the California Department of Public Health site: http://eziz.org/. **Vaccines must be billed with the appropriate administration code and the vaccine detail code.**

CHAPTER 12: CARE MANAGEMENT PROGRAM

The California Health & Wellness Plan care management model is designed to help your members obtain needed services from community resources, whether they are covered within the California Health & Wellness Plan array of covered services, or from other non-covered venues. California Health & Wellness Plan's model supports its provider network, including individual practices and large multi-specialty group settings.

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.

The program includes a systematic approach for early identification of eligible members, administration of a needs assessment, and development and implementation of an individualized care plan. The care plan includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our care management team integrates covered and non-covered services and provides a holistic approach to a member's medical, as well as function, social and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care management team is available to help all providers manage their California Health & Wellness Plan members. Listed below are programs and components that are available and can be accessed through the case management team. We look forward to hearing from you about any California Health & Wellness Plan members that you think can benefit from the addition of a California Health & Wellness Plan case management team member.

To contact a care manager call:

California Health & Wellness Plan
Care Management Department
Phone: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
Fax: 1-855-556-7909
www.cahealthwellness.com

Maternal Mental Health Screening Requirement

Provider Responsibilities

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

Providers serving California Health & Wellness Plan (CHWP) members can use one of the following screening tools:

- 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 CHWP's Case Management Department for further assistance with the member's mental health needs. To make a referral, contact CHWP at 1-877-658-0305 and ask for Case Management.

Pregnancy Program

AB 2193 also requires health care service plans and health insurers to develop a maternal mental health program. The program must be consistent with sound clinical principles and processes.

CHWP offers a pregnancy program to pregnant members. The program provides customized support and care needed for a healthy pregnancy and baby. It helps pregnant members access medical care, educates them about their health care needs and assists with social needs and concerns. The program uses the Edinburgh Postnatal Depression Scale to assess for mental health needs of pregnant members and facilitates referrals to a mental health specialist as needed.

Refer members to the pregnancy program by contacting CHWP at 1-877-658-0305 and asking for Case Management.

Start Smart for Your Baby® (SSFB) and High Risk Pregnancy Program

Start Smart for Your Baby® incorporates the concepts of case management, care coordination and disease management in an effort to teach pregnant members how to have healthier babies. SSFB has evolved into a complete program that promotes education and communication between pregnant members, case managers, and physicians to support a healthy pregnancy and first year of life for babies.

Our multi-faceted approach to prenatal and postpartum care includes provision of extensive member outreach, wellness materials and intensive case management. This approach reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

The SSFB program is comprised of multiple components that allow California Health & Wellness Plan to identify more pregnant members, and interact with them earlier in pregnancy. The aim is to decrease pre-term delivery and improve the health of moms and their babies. Start Smart is a unique perinatal program that follows women up to one year after delivery. A case manager with obstetrical nursing experience serves as the primary case manager for members at high risk of early delivery or who experience complications from pregnancy due to medical issues. A social worker, or program specialist, serves as the primary care coordinator for members who experience complications from pregnancy due to social issues.

California Health & Wellness Plan offers a premature delivery prevention program by supporting the use of Makena injections. When a physician determines that a member is a candidate for Makena, which use has shown a substantial reduction in the rate of pre-term delivery, he/she writes a prescription for Makena. With agreement from the member the California Health & Wellness Plan case manager follows up with the member and completes an assessment regarding compliance. The nurse remains in contact with the member and the prescribing physician during the entire treatment period. The care manager can help to coordinate the ordering and delivery of the Makena directly to the physician's office. Contact the California Health & Wellness Plan high-risk pregnancy department for enrollment in the Makena program.

Post Discharge Follow-up Program

The post discharge follow-up program provides member outreach in an effort to coordinate care and promote continuity of service to members as they move from an acute care setting. The initial post discharge outreach call is generally made within the first 72 hours of discharge from the hospital. The program seeks to facilitate members' access to follow-up care, home care services, and medication while preventing secondary health conditions or complications, re-institutionalization, re-hospitalization or unnecessary emergency room use. Members with identified complex conditions, functional, or social needs are referred to Case Management for further follow up and coordination of care.

Emergency Department (ED) Diversion Program

The ED diversion program provides outreach to members with frequent ED usage and assists them with resources and facilitates collaboration with their physician to increase the provision of preventative and non-emergent acute care services at the appropriate level of care. Members with identified complex conditions including behavioral health or substance use, functional, or social needs are referred to Case Management for further follow up and coordination of care.

Case Management

Clinical licensed nurses lead our case management (CM) teams and are familiar with evidence-based resources and best practice standards. Additionally, they have experience with the population, the barriers and obstacles they face, and how socioeconomic factors impact their ability to access services. The California Health & Wellness Plan CM teams manage care for

members whose needs are functional and social as well as those with complex conditions. Children with special healthcare needs are at special risk and are also eligible for enrollment in case management. California Health & Wellness Plan uses a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices. Case managers partner with the primary care physician to support members to help them achieve their self-management health care goals. To refer a member for case management, providers can use the Case Management Referral Form, which can be accessed by using the following link: Care Management Referral Form.

Complex Cancer Care

Medi-Cal members with a qualifying complex cancer diagnosis can request a referral from their provider to get medically needed care from a contracted cancer center, such as a:

- National Cancer Institute (NCI)-designated comprehensive cancer center,
- Site affiliated with the NCI Community Oncology Research Program (NCORP), or
- Qualifying academic cancer center.

Members also have the option to request treatment at an out-of-network cancer treatment provider.

What is a complex cancer diagnosis?

A complex cancer diagnosis includes those listed below. These diagnoses are subject to updates.

- Blood disorders/diseases, malignancies;
- Acute leukemia;
- Advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma including blastic plasmacytoid dendritic cell neoplasm (BPDCN) and T-cell leukemias and lymphomas;
- Advanced stage (stage IV metastatic cancer), relapsed solid tumors refractory to standard FDA-approved treatment options; and
- Advanced stage rare solid tumors for which there is no known effective standard treatment options.

How referrals to an out-of-network cancer center work

A member can get medically needed services from an out-of-network provider but there must be a **payment agreement** in place with California Health & Wellness Plan (i.e., letter of agreement or LOA). This includes:

- When a member requests a referral through an out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center, or a member chooses a different type of cancer treatment provider,

  or
- When an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center refers a member diagnosed with a complex cancer to an out-of-network specialist.

All members considered as potential transplant candidates should be referred to the California Health & Wellness Plan Case Management Department for assessment and case management

services. Each candidate is evaluated for coverage requirements and referred to the State agency as appropriate.

MemberConnections® Program

MemberConnections® is a California Health & Wellness Plan program designed to promote preventive health practices and connect members to quality health and community social services. MemberConnections Representatives are recruited from the communities that we serve and provide grassroots support to our members and providers.

MemberConnections Representatives:

- Provide information on how to schedule appointments, appropriate use of preventive, urgent and emergency care services, covered benefits and other programs available to members
- Conduct phone outreach and home visits – expanding the reach of our integrated care coordination team
- Assist with finding and coordinating community resources for members
- Participate in special educational programs, health fairs and community events for members

To make a referral for the MemberConnections Program, providers can call Provider Services at (877) 658-0305 or fax a Care Management Referral Form, which is located on www.CAHealthwellness.com and can be accessed by using the following link: Care Management Referral Form.

Chronic Care/Disease Management Programs

As a part of California Health & Wellness Plan services, Chronic Care Management Programs (CCMP) is offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Envolve PeopleCare, Centene's disease management subsidiary, administers California Health & Wellness Plan chronic care management program. Envolve PeopleCare's programs promote a coordinated, proactive, disease-specific approach to management that improves members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. California Health & Wellness Plan programs include but are not limited to: asthma, diabetes, heart failure, hypertension, weight management, and tobacco cessation.

Not all members having the targeted diagnoses are enrolled in the CCMP. Members with selected disease states may be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions are referred for case

management program evaluation. To refer a Member for chronic care management call:

California Health & Wellness Plan
Health Coach
(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)

Private Duty Nursing Case Management Requirements

The following describes California Health & Wellness Plan (CHWP's) responsibilities related to case management/care coordination services that have been approved for private duty nursing (PDN) services for Medi-Cal members under age 21 pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. CHWP, with assistance from independent practice associations (IPAs) delegated to provide utilization management for such members, is responsible for case management requirements.

Prior authorization

PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.[1]

Submit prior authorization requests for PDN services as indicated:

Providers participating through IPAs

Providers participating through an IPA must contact their IPA, follow the IPA's prior authorization process and use the IPA's forms.

Direct Network providers

Direct Network providers must request prior authorization by completing a Prior Authorization form and faxing it to the CHWP Health Care Services Department at 1-866-724-5057. The form is available on the provider website under *Provider Resources > Manuals, Forms and Resources.*

For CCS-eligible conditions

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

Requirements

- PDN services require an authorization for all members under age 21.
  - If the IPA is delegated for utilization management, the IPA is responsible for completing the authorization.
  - If the IPA's member is receiving PDN services through CCS, CCS is responsible for the authorization.

- Whoever completes the authorization must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

- All members under 21 receiving PDN services must be case-managed.
- Providers must submit a referral to CHWP's Case Management Department for members under 21 receiving PDN services approved by the IPA, and for their members receiving PDN services through CCS or another entity.
- Providers can submit a referral to CHWP's Case Management Department by completing and faxing the Case Management Referral Form to 1-855-556-7909. The form is available on the provider website under *Provider Resources > Manuals, Forms and Resources.*

Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012 outlines the requirements.

CHWP and IPAs delegated for utilization management are contractually obligated to provide case management/care coordination services to members. Specifically, for Medi-Cal eligible members under age 21 who have had PDN services approved, managed care health plans are required to provide case management/care coordination, as set forth in the CHWP contract, and to arrange for all approved PDN services, whether or not CHWP is financially responsible for the PDN services.[2]

PDN case management/care coordination responsibilities

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

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

Note, members approved for PDN services by delegated IPAs are identified via the delegated IPA's monthly utilization management Authorization Request (AR) source data log submission. Fifteen days post log submission, the list of approved members is provided to CHWP's Case Management Department to monitor care coordination.

Members may choose not to use all approved PDN service hours, and CHWP and delegated IPAs 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.

Compliant policies and procedures

CHWP and delegated IPAs are required to issue new or revised policies and procedures that comply with the requirements of APL 20-012. CHWP must submit copies of the new or updated policies and procedures to their Managed Care Operations Division Contract

Manager for review and approval. Delegated IPAs' policies and procedures must meet APL 20-012 requirements and either be submitted to CHWP or be made available to CHWP upon request. Such policies and procedures must be consistent with the section below about monitoring and oversight of delegated IPAs.

Notice to members

CHWP or the delegated IPA is required to issue a notice to every member under the age of 21 for whom it has currently authorized PDN services on or before July 31, 2020. The notice must:

1. Explain that CHWP or the delegated IPA has primary responsibility for case management of PDN services.
2. Describe the case management services available to the member in connection with PDN services, as set forth above.
3. Explain how to access those services.
4. Include a statement that the member may:
5. Utilize CHWP's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services;
6. File a Medi-Cal fair hearing as provided by law; or
7. Email DHCS directly at EPSDT@dhcs.ca.gov.
8. Include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California at 1-888-852-9241.

Monitoring and oversight

DHCS will audit CHWP compliance with the PDN services case management policy outlined in APL 20-012 and the case management requirements set forth in CHWP's contract with DHCS. If CHWP fails to comply with the requirements of the APL or the case management requirements in CHWP's contract, DHCS may require a corrective action plan and/or assess monetary penalties as provided for in the CHWP contract and any applicable state or federal statutes and regulations.

Monitoring and oversight of delegated IPAs

CHWP's Delegation Oversight Department will monitor and evaluate your compliance to all requirements through CHWP's annual compliance audit in the following areas:

- Review of EPSDT policies and procedures including:
  - Approval of services that are medically necessary for EPSDT eligible members.
  - Communicating the approval duration/number of approved services/hours if applicable.
  - Assisting the CHWP Case Management Department with case management and care coordination services for EPSDT members regardless of financial responsibility for services approved. If the IPA was not the entity to approve the services, the IPA is still required to assist with the provision of case management services as needed or requested by the member.
  - Refer members for whom PDN services have been approved or for whom the IPA is aware have been approved by another entity (such as CCS) to CHWP's Case Management Department to monitor care coordination.
- Review of procedures for assisting CHWP's Case Management Department with requests for PDN services including:
  - Validation that the home health agency/provider of PDN services is enrolled as a Medi-Cal provider.
  - Assisting the CHWP Case Management Department with contacting home health agencies and enrolled individual nurse providers on the member's behalf.
  - Arranging for all PDN service hours, as needed or requested by the member.
  - Documentation of all attempts to identify PDN services for the member and the member's refusal to use all PDN hours approved.
- Evidence that the IPA is actively assisting CHWP to increase the network of private duty nursing services by:
  - Assisting eligible home health agencies/individual providers to enroll as Medi-Cal providers.
  - Assisting the CHWP Case Management Department with leveraging home health agencies and individual nurse providers (in combination if needed) to meet members' needs.
- Additional activities as identified

[1] For more information, refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012.

[2] Acceptance of available PDN services is at the member's discretion. Members are not required to use all approved PDN service hours.

Independent Practice Associations (IPA) Performance Scorecard

As the health care industry in California continues to demand increased performance and value, California Health & Wellness Plan has improved our delegation program tools to include an enhanced IPA Performance Scorecard to evaluate IPAs in seven performance areas. Delegated IPAs are reviewed for performance measures including grievances, contractual financial requirements, delegated medical management, service and quality. The IPA scorecard brings these together in a 360-degree view of performance through an executive dashboard format, with the goal of helping ensure that delegated IPAs are meeting or exceeding standards. The resulting performance management system is governed by the Plan's delegation oversight process.

The IPA Performance Scorecard is used to:

- Ensure transparency in performance.
- Jointly identify opportunities to improve performance and commit to developing performance improvement plans that are regularly reviewed at joint operation meetings (JOMs) and regular meetings.
- Ensure performance exceeds minimum performance standards.
- Serve as a catalyst for corrective action and improvement plans.
- Align performance to performance standards, penalties and rewards outlined in IPA contracts.

Dissemination of scorecard results

IPAs will receive individualized scorecard results electronically on a quarterly basis via JOMs. Results, opportunities and actions are reviewed in JOMs and workgroups for IPAs with minimum membership thresholds.

Performance scoring

IPA performance is measured in seven key performance areas including quality, delegation oversight utilization management (UM), delegation oversight claims, risk adjustment, financial solvency, network and encounters. Multiple measures are compiled and calculated by performance area. Findings are weighted by membership to form the performance score, defined through the following scale:

- 80% or greater: Performing – meeting/exceeding performance targets.
- 50-79%: Monitoring – inconsistently meeting performance targets.
- Less than 50%: Below standard – consistently below performance targets.

Performance management

Continued low performance may result in a corrective action plan (CAP), with expectation of improvement within a specified time-period. If performance does not improve as expected and/or as agreed, an escalation process may be activated. If necessary, formal action may be taken, which may include, but is not limited to, the following:

- Request for formal corrective action.
- A reduction in capitation.
- A freeze on enrollment.
- Revocation of delegation.
- Contract termination.

All actions taken are subject to the terms of the IPA contract.

Performance areas

Performance Area	Metric	Definition	LOB	Cadence
Quality	Quality Score Avg Rate	Quality HEDIS® priority measures as compared to the existing, most available QC benchmarks by PPG. A score is attributed to each measure's performance against the benchmark, then an average of all scores is provided as the "Quality Score". To determine ranking of scores that can fall into each of the 5 performance categories; the Quality scores were ranked across all eligible PPGs by population of interest.	Commercial (Comm)/ Medi-Cal (MCL)/ Medicare (MCR)	Monthly
	CAHPS	CAHPS stands for Consumer Assessment of Healthcare Providers and Systems. It is a measure of member experience for Medicare providers.	MCR	Annual
Delegation Oversight - UM	Overall Compliance Rate	The utilization management PPG scorecard embodies an overall measurement of the PPG compliance rate based on their annual audit score and their turn around timeliness scores	Comm/MCL/MCR	Quarterly

Performance Area	Metric	Definition	LOB	Cadence
		for authorization during the previous quarter.		
Delegation Oversight - Claims	% Claims paid within 30 Calendar days	Total count of all claims paid within reporting quarter and number of those claims processed timely.	MCL/MCR	Quarterly
	% Provider Dispute Resolution (PDR) Resolved within 45 Working days	Total count of all provider disputes processed within reporting quarter and number of those provider disputes processed timely.	Comm/MCL	Quarterly
	% Claims paid within 45 Working days	Total count of all claims paid within reporting quarter and number of those claims processed timely.	Comm	Quarterly
	% PDR Resolved within 30 Calendar days	Total count of all provider disputes processed within reporting quarter and number of those provider disputes processed timely.	MCR	Quarterly
Risk Adjustment	Build-up Risk Adjustment Factor (RAF)	Raw Risk Adjustment score based on all Encounters and Alternative Submission Method (ASM) received as of the data refresh date.	Comm/MCR	Monthly
	MWOV	Represents members without visits as of the data refresh date.	Comm/MCR	Monthly
	Recapture Rate	Represents the percent of suspected conditions captured by the data refresh date.	Comm/MCR	Monthly

Performance Area	Metric	Definition	LOB	Cadence
Financial	Financial Solvency (blue book rating)	A solvency ratio is a key metric used to measure an PPG's ability to meet its debt and other obligations.	Comm/MCL/MCR	Monthly
Network	Access – Provider Appointment Availability Survey (PAAS)	Survey data collected to indicate the % availability of timely access to provider appointments.	Comm/MCL/MCR	Annual
	PTMPY Grievances	PTMPY (Per Thousand Members Per Year) rates are calculated using the total number of grievances, divided by total member months and multiplied by 12,000 (1,000 x 12 months).	Comm/MCL/MCR	Quarterly
	Annual Network Adequacy	Annual Subnetwork Certification for Medi-Cal. The Plan certifies delegated at-risk subnetworks to provide adequate access to members assigned to them based on a set of criteria required by DHCS for services they are at-risk for. Pass/Fail metric.	MCL	Annual
Encounters	Total PMPY	This is a measurement of the Per Member Per Year Visits received in Encounters.	Comm/MCL/MCR	Annual
	Timeliness 0-60 Days	Shows the percent of Encounters received up to 60 Days from the date of service.	Comm/MCL/MCR	Quarterly

CHAPTER 13: BEHAVIORAL HEALTH

Overview

Outpatient Mental Health Services for treatment of mild to moderate mental health conditions are a benefit covered by California Health & Wellness Plan. California Health & Wellness Plan administers this benefit through its behavioral health partner, MHN Services (MHN). This section provides information on how the benefit is administered through MHN, including requirements and points of contact for more information. If you have questions about the outpatient mental health service benefit contact California Health & Wellness Plan, at 1-877- 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Services and Diagnoses Covered Under Plan Benefit

MHN works with its network providers to deliver medically necessary services for the treatment of mild to moderate mental health conditions as authorized under the Medi-Cal plan, including:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition;
- Psychiatric consultation for medication management; and
- Applied behavioral analysis.

All services performed must be medically necessary.

MHN complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and the interim final rules as well as final ruling requiring parity of quantitative limits (QTL) and non-quantitative limits (NQTL) applied to mental health (MH)/substance use disorder (SUD) benefits. Processes for prior authorization and covered service provision are administered in a manner no more stringent than such processes are applied for medical/surgical benefits.

State Requirements for Providing Behavioral Health Treatment and Services

All practitioners participating in the California Health & Wellness Plan network must comply with the following standards in accordance with California Health and Safety Code section 1374.73 and California Insurance Code section 10144.51, when providing behavioral health treatment for pervasive developmental disorder or autism spectrum disorders (ASDs) for California Health & Wellness Plan members.

Participating providers must ensure that qualified autism service professionals or paraprofessionals are supervised by a qualified autism service provider when providing behavioral health services and treatment for pervasive developmental disorder or ASDs. California Health & Wellness Plan covers applied behavioral analysis (ABA) when medically necessary for California Health & Wellness Plan members diagnosed with ASDs.

Authorization Process

Some behavioral health services require prior authorization. For questions about the services that require authorization or behavioral health referrals, contact CHWP at 1-877-658-0305.

Behavioral Health Utilization Management Program

The purpose of MHN's Utilization Management (UM) program's procedures and clinical practice guidelines is to promote treatment specific to the member's condition and provide the most clinically appropriate level of care. In order to meet our objectives, providers must participate and adhere to our programs and guidelines.

The MHN UM team is comprised of qualified behavioral health professionals whose education, training and experience are commensurate with the UM reviews they conduct.

The MHN UM program strives to make certain that:

- Member care meets MHN medical necessity criteria;
- Treatment is specific to the member's condition, is effective, and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided comply with MHN quality improvement requirements and UM policies and procedures are systematically and consistently applied; and
- Focus for members and their families' centers on promoting resiliency and hope.

MHN's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. MHN's medical necessity criteria are used for the approval of medical necessity; plans of care that do not meet medical necessity guidelines are referred to an MHN medical director for review or peer-to-peer discussion.

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when medical necessity criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health practitioners providing treatment for the member.

To determine medical necessity, MHN uses criteria and guidelines set forth by the American Psychological Association as well as criteria and policies that have been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations (i.e., *American Psychological Association, Hayes Medical Technology Directory)* in order to promote appropriate use of services and improved health outcomes.

Continuity of Care

MHN recognizes the importance of providing continuity of care for newly enrolled members, particularly if they have been receiving behavioral health care from providers that are not currently in the MHN network. When members are newly enrolled and have been previously

receiving behavioral health services, MHN continues to authorize care as needed to minimize disruption and promote continuity of care. MHN works with nonparticipating providers (those that are not contracted and credentialed in MHN's network) to continue treatment or create a transition plan to facilitate transfer to a participating MHN provider.

In addition, if MHN determines that a member is in need of services that are not covered benefits, the member is referred to an appropriate provider and MHN continues to coordinate care including discharge planning.

Integrating BH Care

We encourage and support collaborative efforts among primary care physicians (PCPs), other medical/surgical healthcare providers, and behavioral health providers. We support whole-person health care because physical conditions and mental illness are interdependent and the treatment of both must be coordinated.

Physical health conditions can and often do exacerbate mental health conditions or can trigger mental health issues such as depression following a cardiac event. Mental health conditions can and often do impact physical health conditions.

The treatment and medication regimens for physical and mental health conditions can interact negatively.

Even differential diagnosis can be complicated if the assessment fails to consider potential physical causes for apparent mental conditions, such as psychosis-like symptoms triggered by high liver enzymes in members with liver disease.

Communication with the Primary Care Physician

CHWP encourages ongoing consultation between PCPs and their members' behavioral health providers. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

CHWP recommends that you use available communications means to coordinate treatment for members in your care. All communication attempts and coordination activities must be clearly documented in the member's medical record.

MHN requires that its network behavioral health providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process.

Behavioral Health Case Management (CM)

The Case Management Department provides a unique function at the health plan. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance and facilitate positive treatment outcomes through the proactive identification of members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. CHWP case managers are licensed behavioral health professionals with at least three years' experience in the mental health field.

Case manager functions include:

- Early identification of members who have disabilities.
- Assessment of member's risk factors and needs.
- Active coordination of care linking members to behavioral health practitioners and as needed medical services; including linkage with a physical health case manager for members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed.
- Development of a case management plan of care.
- Referrals and assistance to community resources and/or behavioral health practitioners.
- For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, CHWP offers care coordination.

Providers can utilize case managers and care coordinators to help support members. Case managers and care coordinators can make referrals to community resources, help the member communicate with behavioral health providers, and help resolve medical and behavioral health treatment access issues. If a provider identifies a member for referral to CHWP's Case Management Department, or if a provider needs assistance in coordinating a member's care, the provider should contact CHWP at 1-877-658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Coordination of Care

CHWP's coordination of care process is designed to support the coordination and continuity of care between providers and settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved providers and between providers and patients/caregivers. CHWP works closely with providers to maintain continuity of care, and minimize disruption of services for members during transitional periods.

Continuity of health care may have different meanings to various types of caregivers, and can be of several types:

- Continuity of information, which includes information on prior events that is used to provide care that is appropriate to the patient's current circumstance.
- Continuity of personal relationships, recognizing that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management.

No Wrong Door for Mental Health Services Policy

This policy allows members who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the member is transferred to the other delivery system due to their level

of impairment and mental health needs. In certain situations, members may receive coordinated, non-duplicative services in multiple delivery systems, such as when a member has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

California Health & Wellness Plan (CHWP) provides or arranges for the provision of the following:

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

NSMHS listed above applies to the following populations:

- Members ages 21 and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders.
- Members under age 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis.
- Members of any age with potential mental health disorders not yet diagnosed.

Consistent with W&I Code section 14184.402(f), clinically appropriate NSMHS are covered by CHWP even when:

1. **Services provided during the assessment period prior to a determination of a diagnosis, during the assessment period or prior to determination of whether NSMHS criteria are met.** CHWP and county mental health plan (CMHPs) will not deny or disallow reimbursement for NSMHS provided during the assessment process described above if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS.
2. **Services not included in an individual treatment plan.**
3. **The member has a co-occurring mental health condition and substance use disorder (SUD)**.
   CHWP and CMHP will not deny or disallow reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring

SUD, when all other Medi-Cal and service requirements are met. Similarly, CHWP covers clinically appropriate SUD services delivered by CHWP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) whether or not the member has a co-occurring mental health condition. Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties cover clinically appropriate DMC/DMC-ODS services delivered by DMC/DMC-ODS providers, respectively, whether or not the member has a co-occurring mental health condition.

4. **Concurrent NSMHS and SMHS.** Members may concurrently receive NSMHS from a CHWP provider and SMHS via a CMHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. CHWP and CMHP will not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services.

Any concurrent NSMHS and SMHS for adults and children under ages 21, will be coordinated between CHWP and the local CMHP to ensure member choice. CHWP will coordinate with local CMHP to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process.

- Members with established therapeutic relationships with a CHWP provider may continue receiving NSMHS from the CHWP provider (billed to CHWP), even if the member simultaneously receives SMHS from a CMHP provider (billed to the CMHP), as long as the services are coordinated between the delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).
- Members with established therapeutic relationships with a CMHP provider may continue receiving SMHS from the CMHP provider (billed to the CMHP), even if the member simultaneously receives NSMHS from a CHWP provider (billed to CHWP), as long as the services are coordinated between these delivery systems and are non-duplicative.

Screening and transition of care tools

Per APL 22-028, DHCS developed the following standardized adult and youth (under age 21) screening and transition of care tools for Medi-Cal managed care plans (MCPs) and county mental health plans to use:

- Screening tools to determine the most appropriate Medi-Cal mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or county mental health plan seeking mental health services.
- Transition of care tool to ensure Medi-Cal members receive timely and coordinated care when completing a transition of services to the other delivery system or when

adding a service from the other delivery system to their existing mental health treatment.

CHAPTER 14: CREDENTIALING AND RECREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that California Health & Wellness Plan maintains a high quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this aim by validating the professional competency and conduct of our providers. This includes verifying licensure, board certification, and education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base. Participating providers must meet the criteria established by California Health & Wellness Plan, as well as government regulations and standards of accrediting bodies.

California Health & Wellness Plan requires re-credentialing at a minimum of every 3 years because it is essential that we maintain current provider professional information. This information is also critical for California Health & Wellness Plan's members, who depend on the accuracy of the information in its provider directory.

Note: In order to maintain a current provider profile, providers are required to notify California Health & Wellness Plan of *any relevant changes to their credentialing information in a timely manner.*

Which Providers Must be Credentialed?

All of the following providers are required to be credentialed:

- Physicians-MD
- Osteopathic Practitioners-DO
- Podiatrists-DPM, Chiropractors-DC
- Oral Surgeons –DMD
- Allied Health Professionals, including:
    - Psychologists
    - Physician Assistants –PA
    - Nurse Practitioners-NP
    - Nurse Midwives-NMW
    - Optometrists
    - Physical Therapists
    - Occupational Therapists
    - Speech and Hearing Specialists
    - Licensed Clinical Social Workers (LCSW)
    - Licensed Marriage Family Therapists (LMFT)

Information Provided at Credentialing

All new practitioners and those adding practitioners to their current practice must submit at a **minimum** the following information when applying for participation with California Health & Wellness Plan to chwp_contracting@cahealthwellness.com:

- A completed, signed and dated California Standardized Credentialing application
    - The California Participating Physician Application can be downloaded here: https://www.pdffiller.com/en/project/30058458.htm?form_id=5465862
    - Alternatively, physicians can authorize California Health & Wellness Plan access to their information on file with the CAQH (Council for Affordable Quality Health Care) www.CAQH.org (to obtain a CAQH ID request form please email us at chwp_contracting@cahealthwellness.com)
- A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
    - The attestation can be completed electronically on the CAQH web Portal. If you do not have CAQH access and are using the California Participation Physician Application, the attestation page can be found on page 8
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with California regulations regarding malpractice coverage or alternate coverage
- Copy of current California Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of California
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 90 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of Medicare Certification (if applicable)

- Documentation of a Passed Survey and Medical Records Review Survey in accordance with MMCD Policy Letters, Title 22, CCR Section 53856, and W and I Code 14182(b)(9)
- Disclosure of Ownership & Controlling Interest Statement

If applying as an individual practitioner or group practice, please submit the following information along with your signed participation agreement:

- A completed, signed and dated California Standardized Credentialing application.
    - The California Participating Physician Application can be downloaded here: https://www.pdffiller.com/en/project/30058458.htm?form_id=5465862.
    - Alternatively, physicians can authorize California Health & Wellness Plan access to their information on file with the CAQH (Council for Affordable Quality Health Care) www.CAQH.org (to obtain a CAQH ID request form please email us at chwp_contracting@cahealthwellness.com)
- A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
    - The attestation can be completed electronically on the CAQH web Portal. If you do not have CAQH access and are using the California Participation Physician Application the attestation page can be found on page 8
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with California regulations regarding malpractice coverage or alternate coverage
- Copy of current California Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of California
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 90 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training

- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of Medicare Certification (if applicable)
- Documentation of a Passed Survey and Medical Records Review Survey in accordance with MMCD Policy Letters, Title 22, CCR Section 53856, and W and I Code 14182(b)(9)
- Disclosure of Ownership & Controlling Interest Statement

If applying as an ancillary or clinic provider, please submit the following information along with your signed participation agreement:

- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally-recognized accrediting body, e.g. TJC/JCAHO)
    - If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency.
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Other applicable State/Federal/Licensures (e.g. CLIA, DEA, Pharmacy, or Department of Health)
- Copy of W-9

If applying as a hospital, please submit the following information along with your signed participation agreement:

- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Hospital/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally-recognized accrediting body, e.g. TJC/JCAHO) - if not accredited by a nationally-recognized body, Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)

- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Copy of W-9

Once California Health & Wellness Plan has received an application, it verifies the following information submitted as part of the Credentialing process (please note that this information is also re-verified as part of the re-credentialing process):

- Current participation in the California Fee-for-Service (FFS) Medi-Cal program
- A California license through the appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Five year work history
- Federal sanction activity individual, managing employee, business interests and business with transactions over $25,000 against the EPLS and LEIE databases

Once the application is complete, the California Health & Wellness Plan Credentialing Committee (Credentialing Committee) renders a final decision on acceptance following its next regularly scheduled meeting.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for provider participation. It is also responsible for termination and direction of the credentialing procedures, including provider participation, denial and termination.

Committee meetings are held at least monthly and more often as deemed necessary.

***Note**: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Re-Credentialing

To comply with accreditation standards, California Health & Wellness Plan re-credentials providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification,

competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all providers, primary care providers, specialists and ancillary providers/facilities previously credentialed to practice within the California Health & Wellness Plan network.

In between credentialing cycles, California Health & Wellness Plan conducts ongoing monitoring activities on all network providers. This includes an inquiry to the appropriate California State Licensing Agency to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, California Health & Wellness Plan reviews monthly reports released by the Office of Inspector General to identify network providers who have been newly sanctioned or excluded from participation in the Medicare or Medi-Cal programs.

A provider's agreement may be terminated at any time if California Health & Wellness Plan's Credentialing Committee determines that the provider no longer meets the credentialing requirements.

Right to Review and Correct Information

All providers participating within the California Health & Wellness Plan network have the right to review information obtained by the health plan that is used to evaluate providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review peer review-protected information such as references, personal recommendations, or other information.

Should a provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to California Health & Wellness Plan's Credentialing Department. Upon receipt of this information, the provider has 14 days to provide a written explanation detailing the error or the difference in information. The California Health & Wellness Plan Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join California Health & Wellness Plan have the right to be informed of the status of their application upon request. To obtain status, contact the Provider Services Department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) or email us at chwp_contracting@cahealthwellness.com.

Right to Appeal Adverse Credentialing Determinations

California Health & Wellness Plan may decline an existing provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the California Health & Wellness Plan network. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. California Health & Wellness Plan will send a written response to the provider's reconsideration request within two weeks of the final decision.

Disclosure of Ownership and Control Interest Statement

Federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medi-Cal agency, and to managed care organizations that contract with the state Medi-Cal agency:

1. The identity of all owners with a control interest of *5%* or greater
2. Certain business transactions as described in 42 CFR 455.105
3. The identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity

California Health & Wellness Plan furnishes providers with the Disclosure of Ownership and Control Interest Statement as part of the initial contracting process. This form should be completed and returned along with the signed provider agreement. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to California Health & Wellness Plan within 30 days of the change. Please contact California Health & Wellness Plan Provider Services Department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) if you have questions or concerns regarding this form, or if you need to obtain another copy of the form.

Site Visits

Site visits are a part of the credentialing/re-credentialing process and are conducted with providers before credentialing is finalized. The full scope Facility Site Review includes Medical Records Review in accordance with MMCD policy letter 14-004. Site Reviews are performed in accordance with applicable MMCD Policy Letters, Title 22, CCR Section 53856, and W and I Code 14182(b)(9). For more information, please see:
http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf; and

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf.

For more information about the full scope Facility Site Review, please see Chapter 19 by using the following link: Facility Site Review.

CHAPTER 15: RIGHTS AND RESPONSIBILITIES

Member Rights

California Health & Wellness Plan members have the following **rights and responsibilities**:

- To be treated with respect, with due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical information as required under HIPAA
- To be provided with information about the organization and its services
- To be able to choose a Primary Care Provider within the Contractor's network
- To participate in decision making regarding their own healthcare, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care received
- To file a grievance or request an Independent Medical Review (IMR) in a threshold language, in alternative formats upon request, and by oral interpretation for other languages upon request, at no cost.
- To receive oral interpretation for grievances or IMRs requiring expedited review at no cost
- To formulate advance directives
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Programs, sexually transmitted disease services and emergency services outside the contracted network
- To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible
- To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record
- To disenroll upon request from California Health & Wellness Plan
- To access Minor Consent Services
- To receive interpretation services at no cost, in all languages, at all key points of contact (medical and non-medical), and in a timely manner appropriate for the situation
- To receive member-informing materials (print documents, signage, and multimedia materials such as websites) translated into threshold languages and made available at no cost
- To receive member-informing materials in non-threshold languages and alternative formats, including Braille, large size print, and audio format upon request, within 21 days

- To receive auxiliary aids/services, and modifications of policies/practices/procedures for a disability within a reasonable time frame appropriate for the situation
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's culture, condition, and ability to understand
- To receive referrals to culturally, linguistically, and disability-responsive community service programs
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Section 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State

Provider Rights

California Health & Wellness Plan providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Within the lawful scope of practice, advise the member and advocate on the member's behalf with respect to any of the following:
    - The member's health status
    - Medical or recommended treatment options, including any information the member needs to decide among relevant treatment options
    - The risks and benefits associated with treatment or non-treatment options
    - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment and express preferences about future treatment decisions
- Receive accurate and complete information and medical histories for members' care
- Expect other network providers to act as partners in members' treatment plans
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration and scopes that is less than requested
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against California Health & Wellness Plan and/or a member
- File a grievance with California Health & Wellness Plan on behalf of a member, with the member's consent

- Have access to information about California Health & Wellness Plan quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact California Health & Wellness Plan Provider Services Department with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of members
- Access California Health & Wellness Plan enrollee demographic profile, language preference, and disability accommodation data, upon request
- To be free from discrimination with respect to participation, reimbursement or indemnification when acting within the scope of his/her license or certification under applicable law solely based on that license or certification

Provider Responsibilities

California Health & Wellness Plan recognizes that there are responsibilities that apply to all of its contracted providers, as well as responsibilities that apply to specific types of providers. See Chapter 10 for a description of the specific PCP, specialist and hospital responsibilities, or use the following links to access the relevant sections on provider-type specific responsibilities (PCP responsibilities; specialist responsibilities; hospital responsibilities).

A set of responsibilities applies to all California Health & Wellness Plan providers, irrespective of provider type. ***All*** California Health & Wellness Plan providers have the **responsibility** to:

- Help members or advocates for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment recommendations, including the responsibility to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options therapies, consultations, and/or tests, including those that may self-administered
  - Inform the member of the benefits, risks and consequences associated with each treatment option or choosing to forego treatment
- Allow members to use their California Medi-Cal ID card as proof of enrollment in California Health & Wellness Plan until the member receives their California Health & Wellness Plan ID card (for more information about use of the Medi-Cal ID card and AEVS to verify eligibility, use the following link: AEVS eligibility)
- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental health, or limited English proficiency

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and any treatment recommendations, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Comply with California Health & Wellness Plan's Cultural, Linguistic, and Disability Access Program requirements and agree to provide information necessary to assess compliance
- Require bilingual providers and/or office staff to complete and submit language capability disclosure forms, and provide quarterly updates of any changes in language capabilities to California Health & Wellness Plan
- Inform members of the availability of California Health & Wellness Plan's cultural, linguistic, and disability access services, facilitate access to these services, and **i**mmediately document a request and/or refusal of services in the data management system
- Inform a member if the proposed medical care or treatment is part of a research experiment and allow the Member the right to refuse experimental treatment
- Refer a member to a CCS-paneled provider if there is sufficient clinical detail to establish or raise a reasonable suspicion that the member has a CCS-eligible medical condition
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members' advance directives and include such documents in the members' medical records
- Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately

- Participate in California Health & Wellness Plan data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by California Health & Wellness Plan
- Comply with California Health & Wellness Plan Medical Management program as outlined in this handbook
- Disclose overpayments or improper payments to California Health & Wellness Plan
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to California Health & Wellness Plan information regarding other insurance coverage
- Notify California Health & Wellness Plan in writing if the provider is leaving or closing a practice
- Contact California Health & Wellness Plan to verify member eligibility or coverage for services, if appropriate
- To the extent possible, invite member participation in understanding the member's medical or behavioral health issues and develop mutually agreed upon treatment goals
- Upon request, provide members with information regarding office or facility location, hours of operation, accessibility, and languages, including the ability to communicate in sign language
- Coordinate and cooperate with other service providers who serve Medi-Cal members such as dental providers, the CCS program, specialty mental health providers, and other providers as appropriate
- If necessary, object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to California Health & Wellness Plan, on an annual basis, any Physician Incentive Plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice, even if there is no substantial financial risk between California Health & Wellness Plan and the physician or physician group
- If a provider is no longer accepting new patients or was previously not accepting new patients but is now accepting new patients, the provider shall notify the Plan of the panel status change within 5 business days.
- If a provider is no longer accepting new patients and is contacted by a member, the provider shall:
    - Direct the enrollee's or potential enrollee's to the Plan.
    - Notify the Plan of inaccurate panel status data within 5 business days.

- Providers must cooperate with updating and/or verifying the provider information as requested or face potential penalties including delay of claims payments, capitation, removal from directories, or possible termination from the network.
- Providers must keep language capability disclosure forms and documentation on file and provide quarterly updates to the Plan regarding any changes in the language capabilities of providers and/or office staff

CHAPTER 16: CULTURAL, LINGUISTIC, AND DISABILITY ACCESS REQUIREMENTS AND SERVICES

California Health & Wellness Plan is committed to providing equal access to quality health care services in a manner responsive to diverse cultural health beliefs and practices, preferred languages, disability access requirements, health literacy, and other needs. California Health & Wellness Plan provides these services in accordance with the U.S. Office of Minority Health Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), and all other relevant federal, state, and local requirements. California Health & Wellness Plan accomplishes this commitment in partnership with participating providers through the following:

- Identifies the cultural, communication, and disability access needs of Members through the following methods:
    - Obtains Updated Member Demographic Information – California Health & Wellness Plan regularly surveys individual Members and updates demographic information including cultural, communication, and disability access needs in the plan's member data system. Information is frequently updated via Member communication through the California Health & Wellness Plan Member Services Department.
    - Conducts Population Needs Assessment – California Health & Wellness Plan administers a population needs assessment (PNA), formerly the Group Needs Assessment (GNA), every year. The PNA identifies the cultural, linguistic, and disability access needs of Members, facilitates the continuous development and improvement of programs and services, and establishes health education program priorities and appropriate levels of intervention for specific health issues and target populations.
    - Maintains the Cultural and Linguistic Program (C&L) Description – California Health & Wellness Plan develops and annually updates a C&L Program Description to address the needs identified in the PNA. The C&L Program Description includes goals, objectives, a timetable, and standards/performance requirements, among other things. The C&L Program Description is developed in collaboration with California Health &Wellness Advisory Committees, such as the Community Advisory Committee (CAC), the Public Policy Committee (PPC), and the Quality Improvement Committee (QIC), and representatives from diverse cultural communities.

To request a copy of the most recent Population Needs Assessment or C&L Program Description, providers should contact California Health & Wellness Plan's Provider Services department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). You can also view the most recent PNA Executive Summary in the "Provider Resources" section at www.cahealthwellness.com.

- Educates members so that they fully understand the health care and services they receive, can participate in their own care, and can make informed decisions by providing cultural, linguistic and disability access services in a timely manner at no cost to members.

Participating Providers are required to:

- Document Cultural/Linguistic/Disability Access Capabilities – Identify, assess, and report on the cultural, linguistic, and disability access capabilities of employees that provide interpretation, translation, or reasonable accommodations. Providers should furnish quarterly updates regarding any changes in language capabilities of providers and/or office staff to California Health & Wellness Plan. Providers are required to submit updates on a quarterly basis, if there are any changes in language capabilities of providers or office staff.

- Provide Medical Care and Information on Treatment Options – Medical care and treatment options should be provided in a manner that is respectful of, and takes into account, diverse cultural beliefs, health literacy rates, and disability access needs. This includes but is not limited to a Member's ability to obtain, process, and understand information.

California Health & Wellness Plan achieves this aim by:

- Updating its Provider Directories in accordance with state contract and regulatory requirements to reflect any changes in the cultural, linguistic, or disability access capabilities of participating providers.

- Providing Personal Support offered by California Health & Wellness Plan MemberConnections® Representatives, Member Services Representatives, and Care Coordination staff to connect Members with cultural, linguistic, and disability-responsive community health and social service resources.

- Providing Health Education Materials to its members. California Health & Wellness Plan is required to make certain that all Member health education materials are at or below a sixth grade reading level and meet the readability and suitability requirements set forth by the Department of Health Care Services. California Health & Wellness Plan will attach and include the approved Non-Discrimination Notice (NDN) and Notice of Language Assistance (NOLA) when materials are mailed to members Providers can access health education materials from the "Health Library" in the "Member" section of the website at www.cahealthwellness.com.

Both California Health & Wellness Plan and Participating Providers are responsible for:

- Providing Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats. This includes but is not limited to: an in-person interpreter upon a member's request; telephone, relay, or video remote interpreting, 24 hours a day, seven days a week. This can also be furnished through other formats, such as real-time captioning or augmentative & alternative communication devices, which promote effective communication.

  Individuals or groups providing interpretation and translation services to Members must meet the standards published by the California Healthcare Interpreters Association (CHIA) including, at a minimum, the following three proficiency standards:

  1. Documented and demonstrated proficiency in English and other language;
  2. Fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and
  3. Education and training in interpreting/translation ethics, conduct, and confidentiality.

- Furnishing Member-Informing Materials (print documents, signage, and multimedia materials, such as websites) translated into the currently identified threshold or concentration standard languages, and provided through a variety of other means. This may include but not be limited to: oral interpretation for other languages upon request; alternate or accessible formats (e.g. accessible PDFs, documents in Braille, large print with 20 point font size or larger, audio format, or captioned videos) upon request or standing request, as needed; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.

- Providing Auxiliary Aids/Services or Modification of Policies and Procedures that facilitate access for Members with disabilities. This includes, but is not limited to: accessible medical care facilities, diagnostic equipment, and examination tables & scales, or modification of policies to permit the use of service animals, or to minimize distractions and stimuli for members with mental health or intellectual/developmental disabilities.

- Informing Members of the availability of cultural, linguistic, and disability access services at no cost to the Member. Communicate this message using brochures, newsletters, outreach and marketing materials; other materials that are routinely disseminated to Members; and at Member orientation sessions and sites where Member receive covered services. California Health & Wellness Plan and its participating providers shall also facilitate access to these services, and document a request and/or refusal of services in the plan or provider's member data system.

To request assistance with any of these cultural, linguistic, or disability access services when serving a California Health & Wellness Plan member, providers should contact California

Health & Wellness Plan's Provider Services department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

California Health & Wellness Plan and Participating Providers share responsibility for:

- Education and Training – All staff, including governance and leadership, must receive ongoing education and training on the following topics, among others:
    - Cultural, linguistic, and disability access service requirements and available resources
    - How to work effectively with interpreters and Members with diverse cultural, linguistic, or disability access needs
    - Understanding the cultural diversity of California Health & Wellness Plan's Members
    - Understanding different group beliefs about illness and health, methods of interacting with providers and the system, and traditional home remedies

- Workforce Development – Recruit, hire, develop and promote a culturally, linguistically, and disability-diverse workforce that reflects the diversity of the Membership and has a personal familiarity with the counties served, cultural norms, and how people access health care.

Providers interested in education and training related to the provision of culturally, linguistically, and disability-responsive health care services should contact California Health & Wellness Plan's Provider Services department at (877) 658-0305 For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Participating Providers are required to, as previously noted:

- Document Cultural/Linguistic/Disability Access Capabilities – Identify, assess, and report on the cultural, linguistic, and disability access capabilities of employees that provide interpretation or translation services during the bi-annual SB 137 process. Providers are required to submit updates on a quarterly basis, if there are any changes in language capabilities of providers and/or office staff.

- Provide Medical Care and Information on Treatment Options in an Appropriate Manner – Medical care and treatment options should be provided in a manner that is respectful of, and takes into account, diverse cultural beliefs, health literacy rates, and disability access needs. This includes, but is not limited to, a Member's ability to obtain, process, and understand information.

California Health & Wellness Plan pursues this objective by:

- Seeking Input from a Community Advisory Committee - California Health & Wellness Plan has a Community Advisory Committee (CAC) that includes community advocates and cultural leaders who represent a cross-section of the member population, including Members who use Managed Care Long Term Supports and Services (LTSS). The CAC makes recommendations and is involved in all policy decisions related to quality improvement, educational,

- Developing Quality Assurance Standards for all cultural, linguistic, and disability access services provided by the Plan and providers to promote the quality, accuracy, and timely delivery of these services at all key points of contact for emergency, urgent, and routine health care services

- Documenting Provider Capabilities During Credentialing - Document the cultural, linguistic, and disability-access capabilities of participating providers during the credentialing process and provide training and tool kits

- Conducting Oversight and Monitoring Activities - Perform on-going oversight and monitoring activities of the Plan, the Plan's language assistance vendors, and participating providers to promote proficiency and compliance with the regulatory requirements related to cultural, linguistic, and disability access

- Providing Access to a Grievance System – Make certain that members have access to and can participate in the grievance system; By participating in the grievance system, members receive at a minimum, written translations and/or oral interpretations of grievance procedures, forms, and plan responses to grievances, access to auxiliary aids & services that assist members with disabilities, and a notice of the availability of oral interpretation for cases requiring expedited review

- Tracking and Reporting Grievances - Track members' complaints and grievances, including the reporting of any that are related to cultural, linguistic, and disability access to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC) for appropriate action

Both California Health & Wellness Plan and Participating Providers share responsibility for:

- Informing Members of Right to File a Grievance – See that members receive information regarding a member's right to file a grievance and seek an independent medical review in threshold, concentration standard languages, and in alternative formats and other languages upon request

Providers with questions related to California Health & Wellness Plan's accountability requirements should contact California Health & Wellness Plan's Provider and Member Services department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

CHAPTER 17: GRIEVANCES AND APPEALS PROCESS

Overview

California Health & Wellness Plan is committed to ensuring that its providers and members can resolve issues through its grievance and appeals process.

California Health & Wellness Plan does not discriminate against providers or members for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance. Furthermore, California Health & Wellness Plan actively monitors its grievance and appeals process as part of its Quality Improvement program, and is committed to resolving issues within establish timeframes and referring specific cases for peer review when needed.

Provider Claim Disputes

California Health & Wellness Plan's providers are able to dispute actions or inactions by California Health & Wellness Plan regarding a specific claim. Please see Chapter 8: Billing and Claims Submission by using this link for more information about the Provider Claims Dispute process (claims dispute process).

Outpatient Pharmacy Benefits & Services Carve Out

California Health and Wellness Plan (CHWP) Medi-Cal pharmacy benefits and services transitioned from managed care to the State's responsibility under the pharmacy benefit program known as Medi-Cal Rx. Appeals and grievances for these benefits and services are the responsibility of Medi-Cal Rx. Disputes regarding the denial of a referral or a prior authorization request should be directed to DHCS State Fair Hearing and not to CHWP. If CHWP receives a grievance related to these services, CHWP will redirect those grievances to Medi-Cal Rx contractor, Magellan Medicaid Administration, Inc. (Magellan), in a timely manner and in the manner outlined by DHCS. If CHWP receives an appeal related to these services, DHCS State Fair Hearing process is responsible. CHWP will redirect those appeals to DHCS State Fair Hearing.

Member Grievance and Appeals

California Health & Wellness Plan maintains a procedure for the receipt and prompt internal resolution of all grievances and appeals that complies with 42 CFR, Part 438, Subpart F and all applicable state and federal laws. California Health & Wellness Plan's grievance system includes a grievance process, an appeal process, and a state fair hearing process. This process is based upon the following definitions of a grievance and an appeal:

- A ***grievance*** is any expression of dissatisfaction to California Health & Wellness Plan by a provider or member about any matter other than a Notice of Action.

- An ***appeal*** is a formal request for California Health & Wellness Plan to change an authorization decision upheld by California Health & Wellness Plan through the grievance and appeal process.

A provider, with the member's written consent, may file a grievance or appeal on behalf of the member. California Health & Wellness Plan refers all members who are dissatisfied with California Health & Wellness Plan or its subcontractors in any respect to the California Health & Wellness Plan Grievances and Appeals Coordinators. The Coordinator reviews and responds to grievances and appeals, and implements the required corrective action. Providers should advise members who need assistance in filing a grievance, appeal or request for State Fair Hearing to contact California Health & Wellness Plan at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

California Health & Wellness Plan assists members as needed in filing a grievance, appeal or request for State Fair Hearing, and the grievance process will address the linguistic, cultural and disability access needs of its members.

Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx

Medi-Cal pharmacy benefits are administered through the Department of Health Care Services (DHCS) fee-for-service delivery system called Medi-Cal Rx. California Health & Wellness Plan (CHWP) Medi-Cal pharmacy benefits and services transitioned to the State's responsibility under the pharmacy benefit program known as Medi-Cal Rx (DHCS APL 20-020). Appeals and grievances for these benefits and services are not CHWP's responsibility.

- **Medi-Cal Rx member appeals** – Appeals involving disagreement with benefit-related decisions, such as coverage disputes, disagreeing with and seeking reversal of a request for prior authorization involving medical necessity, etc., and that are associated with a Notice of Action (NOA) should be directed to California Department of Social Services (CDSS) State Fair Hearing (SFH) via the contacts below and not to CHWP.
    a. By mail:

        California Department of Social Services State Hearings Division
        P.O. Box 944243, Mail Station 21-37
        Sacramento, California 94244-2430

    b. By fax: 833-281-0905
    c. Online: https://acms.dss.ca.gov/acms/login.request.do
    d. By phone: 800-743-8525 (voice) and 800-952-8349 (TTY)

    Medical beneficiaries are no longer required to exhaust any internal and/or administrative DHCS processes prior to requesting a SFH through CDSS. Additionally, under Medi-Cal Rx, Medi-Cal enrollees no longer have the right to apply for an Independent Medical Review (IMR) for pharmacy services carved out to

Medi-Cal Rx (DMHC APL 20-035). If CHWP receives an appeal related to these services, it will redirect it to CDSS State Fair Hearing in a timely manner and in the manner outlined by DHCS.

- **Member complaints and grievances** – A CHWP Medi-Cal member may file Medi-Cal Rx complaints and grievances at any time to Medi-Cal Rx Customer Service Center (CSC), who will administer all aspects of the complaints and grievances processes and related procedures for Medi-Cal pharmacy benefits. Complaints or grievances may be filed with Medi-Cal Rx CSC by telephone at 800-977-2273 or in writing via fax to 800-869-4325. If CHWP receives a Medi-Cal Rx grievance or complaint, it will redirect those issues to Medi-Cal Rx CSC.
- **Provider prior authorization (PA) appeals** – Providers, on behalf of a Medi-Cal beneficiary, may appeal Medi-Cal Rx PA denials, delays and modifications issued on or after January 1, 2022. Providers may submit appeals of PA adjudication results through their Medi-Cal Rx website: https://medi-calrx.dhcs.ca.gov/home/ or by mail clearly identified as appeals, to:

  Medi-Cal CSC, Provider Claims Appeals Unit
  P.O. Box 610
  Rancho Cordova, CA, 95741-0610

  Medi-Cal Rx will acknowledge each submitted PA appeal within three days of receipt and make a decision within 60 days of receipt. Medi-Cal Rx will send a letter of explanation in response to each PA appeal. Providers who are dissatisfied with the decision may submit subsequent appeals. Medi-Cal providers may seek a judicial review of the appeal decision, as authorized under state law. For more information about the Medi-Cal Rx provider PA appeal process, please visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

- **Provider claim appeals** – Provider claim appeals to resolve claim payment problems (e.g., resubmission, non-payment, underpayment, overpayment, etc.) for services provided on or after January 1, 2022, may be filed to Medi-Cal CSC. Providers must complete the Medi-Cal Rx provider appeal form and submit the completed form to:

  Medi-Cal CSC, Provider Claims Appeals Unit
  P.O. Box 610
  Rancho Cordova, CA, 95741-0610

Once the Medi-Cal Rx provider appeal form is submitted, Medi-Cal Rx will acknowledge each appeal within 15 days of receipt and make a decision within 45 days of receipt.

The above information about appeals and grievances related to pharmacy was adapted from Department of Managed Health Care All Plan Letter 20-035, DHCS All Plan Letter 20-020 and the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home.

Expectations with Respect to Grievances and Appeals

California Health & Wellness Plan's expectations of its member grievance and appeals process include the following important principles:

- ***Accessible and Timely Due Process*** - The California Health & Wellness Plan conducts its grievance and appeals process in a non-discriminatory manner that promotes timely due process. In this regard, California Health & Wellness Plan:
  - Informs its members of their due process rights
  - Logs and processes grievances and appeals
  - Issues proper notices that are precise and legible
  - Informs its members of continuation of benefits
  - Informs its members of their right to a State Fair Hearing
  - Does not include binding arbitration clauses in California Health & Wellness Plan member choice forms
  - Avoids labeling complaints as inquiries and funneling into an informal review

- ***Member Notification of Process*** – Upon initial enrollment, California Health & Wellness Plan provides members with the Member Handbook, which notifies Members of the procedure for processing and resolving grievances. Providers can also review the members' rights and notification of the grievance process contained in the Member Handbook, which is accessible online by using the following link: Member Handbook. The notification contains specific instructions on how to contact California Health & Wellness Plan's Member Services Department, identifying the Grievance and Appeals Coordinators who process grievances and appeals.

- ***Cultural, and Disability Access Needs*** - The grievance and appeals process is accessible to all members, including those with limited English proficiency or with visual or other communication disabilities. If you have a member with limited English proficiency who needs assistance in filing a grievance or appeal, please contact California Health & Wellness Plan at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

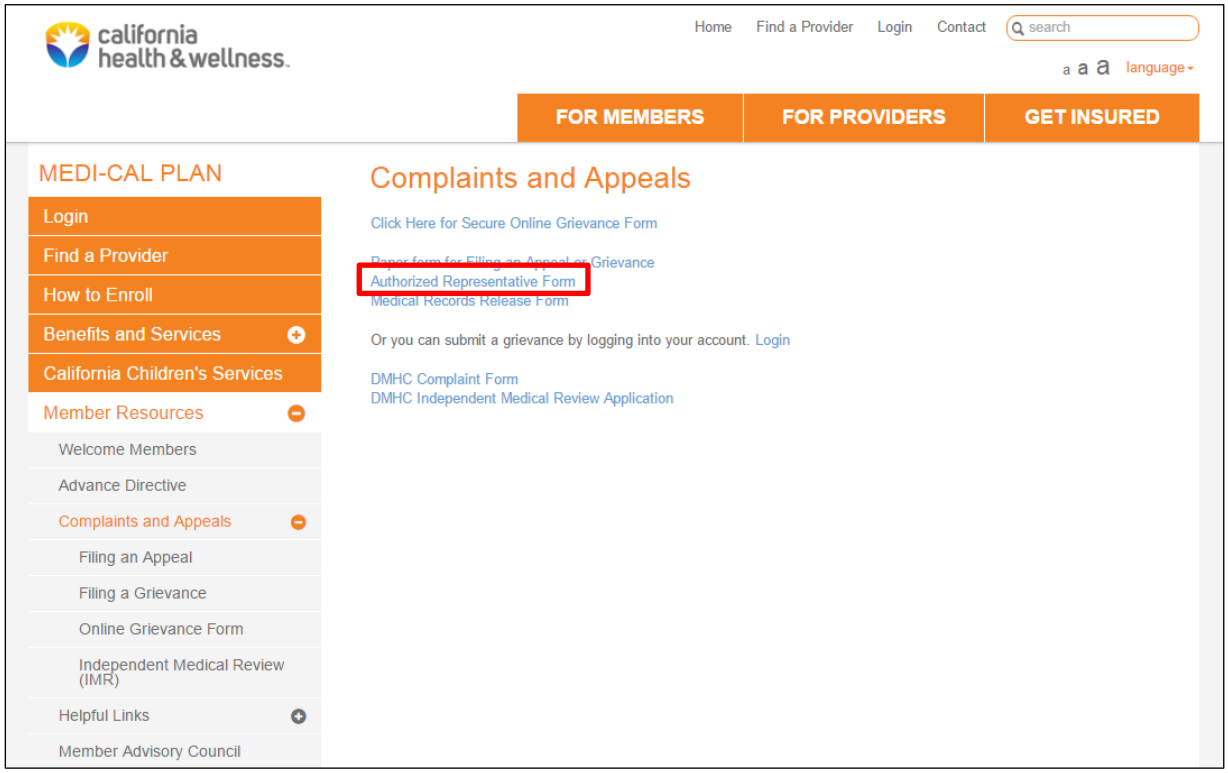
Member Appeals and Grievances Procedure

General Requirements

Who May File a Grievance or Appeal: A member, or authorized representative acting on the member's behalf, may file a grievance or appeal, and may request a State Fair Hearing. **A provider, acting on behalf of the member, may file a grievance or appeal. A provider does**

not need written consent from the member to file a grievance or appeal on the member's behalf.

Member Consent Form: A member consent form that providers may use to obtain written consent from the member is available at the following link of the California Health & Wellness Plan website: **https://www.cahealthwellness.com/members/medicaid/resources/complaints-appeals.html.** To obtain a consent form, click on the "Authorized Representative Form" link.



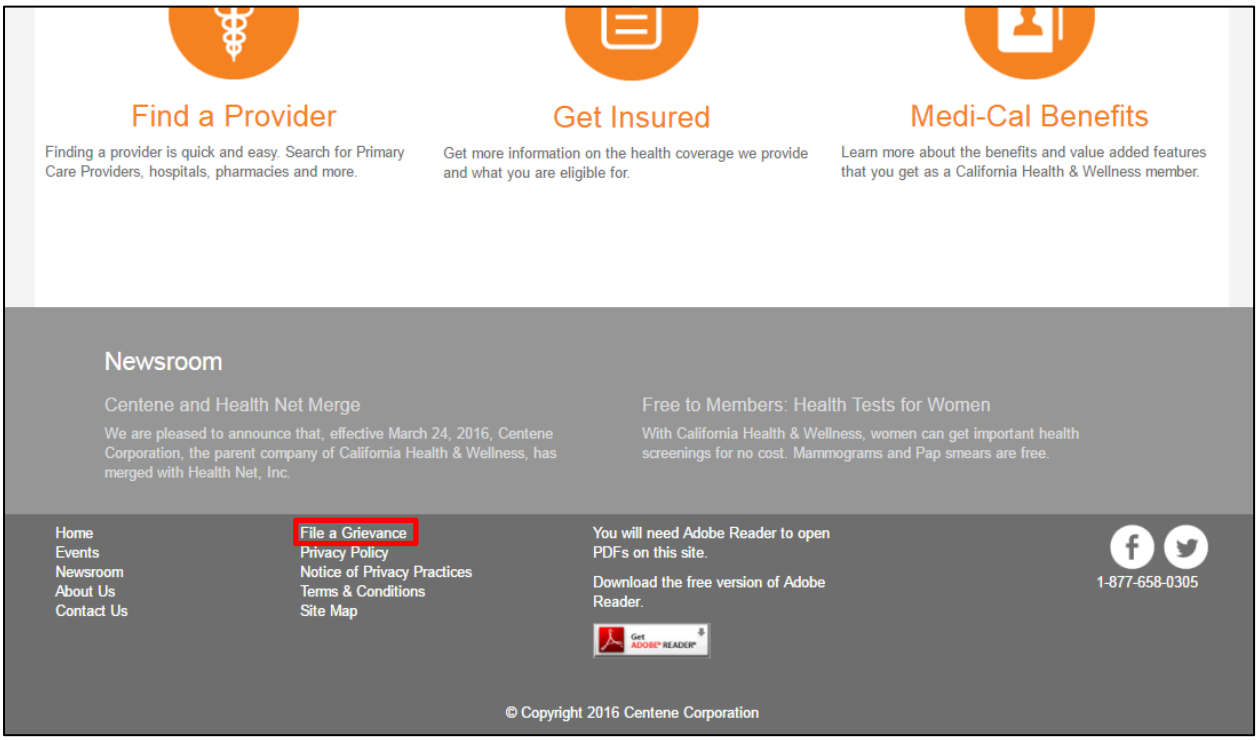
Method of Filing a Grievance or Appeal: A member, or member's authorized representative, may file a grievance or appeal verbally or in writing. California Health & Wellness Plan furnishes members reasonable assistance in completing forms and taking other procedural steps of the Grievance System, including but not limited to the following:

- Notifying members of their right to file a grievance or request an IMR in California Health & Wellness Plan's threshold languages, and in alternative formats and oral interpretation for other languages, upon request
- Translating and distributing grievance and IMR procedures, forms, letters and responses into California Health & Wellness Plan's threshold languages, and in alternative formats and oral interpretation for other languages, upon request
- Making translated forms and procedures readily available to members, contracting providers, contracting facilities, and on the California Health & Wellness Plan web site

- Offering interpretation services and reasonable accommodations for members with limited English proficiency, or with visual or other communicative disabilities who file a grievance or seek an IMR, including relay services and other devices that aid individuals with disabilities to communicate if needed
- Notifying members of the availability of free interpretation services for cases requiring expedited review

Submit a Grievance or Appeal Online: Members and providers may also fill out and submit a request for an appeal or grievance online on the California Health & Wellness Plan website. To submit online:

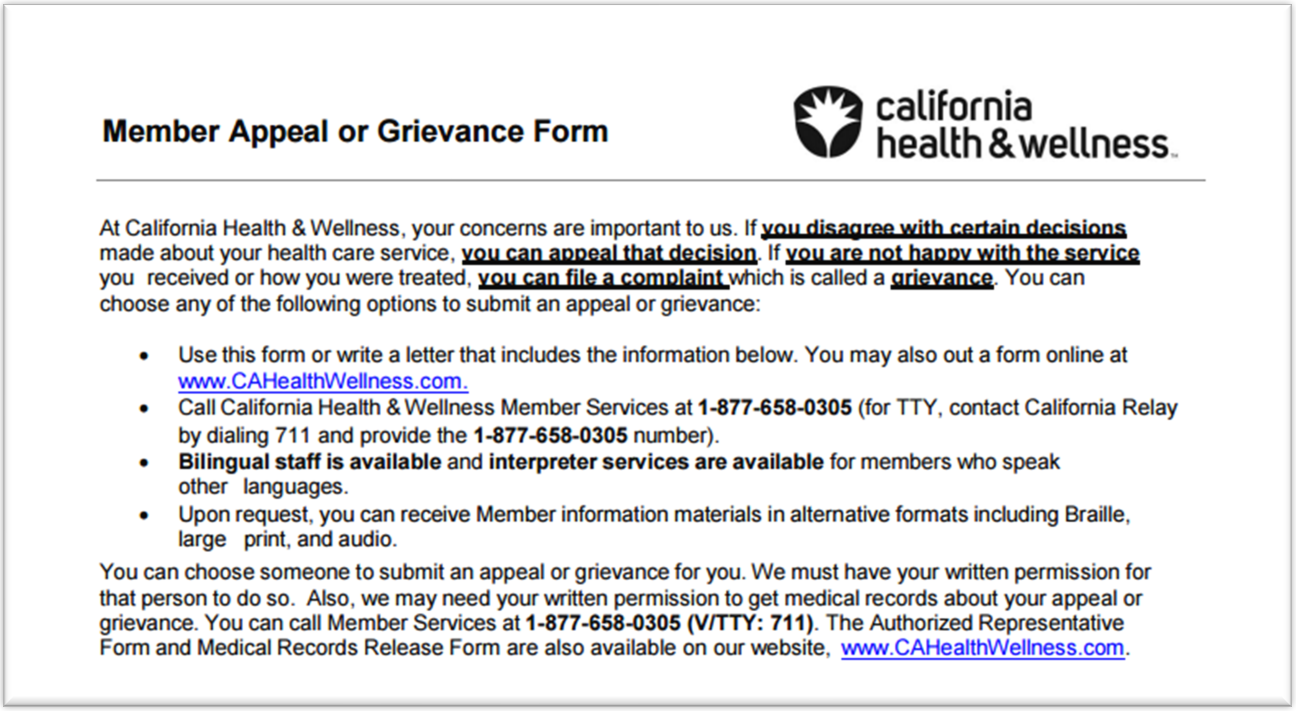
- Log on to www.CAHealthWellness.com
- On the California Health & Wellness Plan home page, click on the "File a Grievance" link, which is located at the very bottom of the page (see screenshot below).



- Then click on the "Click here for secure online grievance form" link at the top of the page. If members already have an account, members can instead submit a grievance by logging into their account
- Follow the on-screen instructions.

Submit a Grievance or Appeal by Fax or Mail: To submit a grievance or appeal by fax or mail, complete a member grievance and appeal form. Grievance forms and a description of the grievance procedure are readily available at each facility and from each contracting provider's office or facility. Grievance forms are provided promptly upon request.

Member grievance and appeal forms are also available on the California Health & Wellness Plan website (please see the screenshot below of the member grievance and appeal form). To access the member grievance and appeal form, use this link (member grievance/appeal form), or log on to California Health & Wellness Plan's website at www.CAHealthWellness.com, click on the "Submit a Grievance" tab in the "For Members" box, and then click on the link "Paper Form for Filing an Appeal or Grievance."



Member Appeal or Grievance Form

california health & wellness

At California Health & Wellness, your concerns are important to us. If **you disagree with certain decisions** made about your health care service, **you can appeal that decision**. If **you are not happy with the service** you received or how you were treated, **you can file a complaint** which is called a **grievance**. You can choose any of the following options to submit an appeal or grievance:

- Use this form or write a letter that includes the information below. You may also out a form online at www.CAHealthWellness.com.
- Call California Health & Wellness Member Services at **1-877-658-0305** (for TTY, contact California Relay by dialing 711 and provide the **1-877-658-0305** number).
- **Bilingual staff is available** and **interpreter services are available** for members who speak other languages.
- Upon request, you can receive Member information materials in alternative formats including Braille, large print, and audio.

You can choose someone to submit an appeal or grievance for you. We must have your written permission for that person to do so. Also, we may need your written permission to get medical records about your appeal or grievance. You can call Member Services at **1-877-658-0305 (V/TTY: 711)**. The Authorized Representative Form and Medical Records Release Form are also available on our website, www.CAHealthWellness.com.

Completed forms may be faxed to: **1-855-460-1009**, or mailed to:

California Health & Wellness Plan
Attn: Appeals and Grievance Coordinator
4191 East Commerce Way
Sacramento, CA 95834

- Investigation of a Grievance or Appeal: California Health & Wellness Plan Appeals and Grievances staff or, if necessary, clinical personnel investigate the grievance or appeal. If the grievance is a quality of care or service complaint, it is routed to California Health & Wellness Plan's Quality Improvement Department for investigation and resolution.

- Making Decisions: California Health & Wellness Plan strives to make certain that its decision makers have not been involved in previous decision making with respect to a specific case; and are health care professionals with clinical expertise in treating the member's condition when deciding the following:

- Appeal of a denial based on lack of Medical Necessity;
- Grievance regarding denial of an expedited resolution of an Appeal; and
- Grievance or Appeal involving clinical issues.

- Notification: California Health & Wellness Plan sends resolution letters to the member within 30 calendar days from the day California Health & Wellness Plan received the initial appeal or grievance request, be it oral or in writing. Response letters include the following information:

  - The result and date of the appeal resolution
  - Member's right to request a State Fair Hearing
  - How to request a State Fair Hearing
  - Right to continue to receive benefits pending a State Fair Hearing
  - How to request the continuation of benefits
  - DHCS and DMHC telephone number
  - The California Relay Services' telephone numbers
  - The California Health & Wellness Plan telephone number
  - DHCS's internet address
  - The statement contained in subsection (b) of Section 1368.02 of the Act

No Punitive Action Against a Provider: California Health & Wellness Plan does not take punitive action against a provider who files a grievance, an appeal or requests an expedited appeal on behalf of a member or supports a member's grievance, appeal or request for an expedited appeal. Furthermore, California Health & Wellness Plan does not discriminate against a provider because the provider filed a contracted provider dispute or a non-contracted provider dispute.

How the Member Grievance Process Works

Overview: The Grievance Process is California Health & Wellness Plan's procedure for addressing member or provider grievances, which are expressions of dissatisfaction about any matter other than a Notice of Action. Where California Health & Wellness Plan is unable to distinguish between a grievance and an inquiry, it is considered a grievance. DHCS and DMHC consider a provider complaint or appeal on behalf of a member as a grievance.

- Filing Grievances: The member, member's authorized representative, or provider (as noted above), may file a grievance orally or in writing.

- Grievance Acknowledgement: California Health & Wellness Plan acknowledges a grievance in writing within 5 *calendar days* of receipt of the grievance. The acknowledgement notifies the complainant of the following:
  The grievance has been received;
  - The date of the receipt; and
  - The name of the plan representative and address of the plan.

- Timely Resolution: California Health & Wellness Plan resolves grievances in a timely manner that is appropriate for the complexity of the grievance and the member's health condition.

- Grievances are resolved within *30 calendar days* from the day California Health & Wellness Plan received the initial grievance request, be it oral or in writing. If you have not received a response from California Health & Wellness Plan within 30 calendar days, please contact the Grievance and Appeals Coordinator noted on the acknowledgement letter. California Health & Wellness Plan sends a written response at the time of resolution. The written response contains a clear and concise explanation of the California Health & Wellness Plan's decision.

Expedited Review of Clinically Urgent Grievances

Overview: California Health & Wellness Plan maintains an expedited review process for Grievances when it determines, the member requests or the provider indicates (in making the request on the member's behalf or supporting the member's request) that the standard resolution timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

- Member's Right to DHCS/DMHC Review of Urgent Grievance: Members are notified of the right to contact DHCS and DMHC regarding the grievance. There is no requirement that the member participate in the California Health & Wellness Plan Grievance System prior to applying to the DHCS for review of the urgent grievance.
- Notice: The notice of the expedited grievance does not need to be in writing, and can be made orally or by phone.
- Response Time: California Health & Wellness Plan determines the response times on a case-by-case basis and considers the member's medical condition when determining the response time. California Health & Wellness Plan makes reasonable efforts to orally notify members of an expedited appeal's resolution immediately after the Appeal decision, but not to exceed *72 hours* after California Health & Wellness Plan receives the Appeal request (whether the Appeal was made orally or in writing).
- DHCS and DMHC Contact: DHCS may contact California Health & Wellness Plan regarding urgent grievances 24 hours a day, seven days a week. During normal work hours, California Health & Wellness Plan responds to DHCS and DMHC within 30 minutes after the initial contact from DHCS and DMHC. During non-work hours, California Health & Wellness Plan responds to DHCS and DMHC within one hour

after the initial contact from DHCS and DMHC. California Health & Wellness Plan provides DHCS and DMHC with a description of its system to resolve urgent grievances, and how DHCS and DMHC can access the plan's urgent grievance system.

Member and Provider Appeal Process

Overview: The appeal process is California Health & Wellness Plan's procedure for addressing member and provider appeals, which are requests for review of a previous decision including a grievance determination or a Notice of Action.

- Filing an Appeal: A member, or provider acting on behalf of a member and with the member's written consent, may file an appeal orally or in writing. Expedited appeals requested orally do not require a subsequent written request.
- Timely Filing of Appeal: An appeal must be filed within *60 calendar days* from the date on the notice of resolution or action or within *10 calendar days* if the member is requesting to continue benefits during the appeal investigation.
- Acknowledgement of Receipt of Filed Appeal: California Health & Wellness Plan acknowledges all oral or written appeals in writing within 5 calendar days of the receipt of a request for an appeal. The acknowledgement letter includes:
  - Subject of the appeal;
  - Explanation of the appeal process; and
  - The Member's rights including the right to submit any comments, documents or evidence relevant to the appeal.

- Expedited Review of Appeals: California Health & Wellness Plan maintains an expedited review process for appeals when California Health & Wellness Plan determines, the member requests or the provider indicates (in making the request on the member's behalf or supporting the member's request) that the standard resolution timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

- Right to Submit Evidence: California Health & Wellness Plan allows the member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. In the case of an expedited appeal, California Health & Wellness Plan informs the member of the limited time available for this opportunity.
- Right to Examine Appeal Documentation: The member and his or her representative has the right to examine the case file, including medical records, and any other documents and records considered during the appeals process, before and during the appeals process.
- Notice of Appeal Resolution (NAR): California Health & Wellness Plan resolves and issues a written decision to the member for each appeal within State-established

timeframes, not to exceed 30 *calendar days* from the day California Health & Wellness Plan received the initial appeal request (whether received orally or in writing).

  - The notice of resolution includes the results of the resolution process, the date it was completed and further appeal rights, if any.

- Expedited Appeal Resolution and Notice: California Health & Wellness Plan resolves expedited appeals and notifies the member regarding the decision as quickly as the member's health condition requires.

California Health & Wellness Plan makes reasonable efforts to orally notify members of an expedited appeal's resolution immediately after the Appeal decision, but not to exceed *72 hours* after California Health & Wellness Plan receives the Appeal request (whether the Appeal was made orally or in writing).

Prior to issuing an adverse determination, the California Health & Wellness Plan Appeal Coordinator contacts the requesting provider to obtain additional information. If the Medical Director denies the expedited appeal request, the Appeal Coordinator makes reasonable efforts to provide the member with prompt oral notice, with written notice sent within three calendar days.

State Fair Hearing System

- Filing a State Fair Hearing Request: A member, his or her representative, or a provider (with the member's written consent) may request a State Fair Hearing at any time during the Grievance or Appeal process and as defined by the state regulations.
- Parties to State Fair Hearing: The parties to a State Fair Hearing include California Health & Wellness Plan, as well as members, their representatives or a representative of a deceased member's estate.
- Timeframe for Submission of a State Fair Hearing Request: The request for a State Fair Hearing must be submitted within *120 calendar days* from the date of the Notice of Appeal Resolution regarding an expedited or standard appeal.

  The request must be submitted *within 10 calendar days* of the date of the notice of resolution, if the member wishes to have continuation of benefits during the State Fair Hearing.
- Expedited State Fair Hearing: This expedited process only applies in cases where California Health & Wellness Plan has denied a requested service and if the issue involves imminent and serious threat to the member's health. The decision is made within 72 hours.
- Plan cooperation: California Health & Wellness Plan cooperates with the state agency in the hearing process and submits a copy of the member's standard appeal of California Health & Wellness Plan's action. The contents of the standard appeal file include:

- Research, medical records and other documents used to make their decision and a summary of the member's appeal
- Evidence used by California Health & Wellness Plan to make its decision
- A copy of the notice of resolution provided to the member and to the State agency within the required timeframe

Independent Medical Review

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against California Health & Wellness Plan, you should first telephone us at **877-658-0305** and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**888-466-2219**) and a TDD line (**877-688-9891**) for those with hearing and speech disabilities. The department's Internet Web site **Error! Hyperlink reference not valid.www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

This section further explains how a member can request an independent medical review from the DMHC.

- Requesting an Independent Medical Review: Members may request an independent medical review for decisions in which California Health & Wellness Plan has:
  - Denied, modified or delayed health care services.
  - Denied reimbursement for urgent or emergency services or that involve experimental or investigational therapies.

  Members who have presented the disputed health care service for resolution by the Fair Hearing process are not eligible for an independent medical review.
- Eligibility for an Independent Medical Review: DMHC makes the final decision when there is a question as to whether a dispute over a health care service is eligible for independent medical review, and whether there are extraordinary and compelling circumstances to waive the requirement that the member first participate in the plan's grievance system.
- How to Submit for an Independent Medical Review: To request an independent medical review, the members must complete an "Independent Medical Review Application". The member may also provide any relevant material or documentation with the application, including but not limited to:

- A copy of the adverse determination by California Health & Wellness Plan or the provider notifying the member that the request for services was denied, delayed or modified based on the determination that the service was not medically necessary;
- Medical records, statements from the member's provider or other documents establishing that the dispute is eligible for review;
- A copy of the grievance requesting the health care service or benefit filed with the plan or any entity with delegated authority to resolve grievances, and the response to the grievance, if any; and
- If expedited review is requested for a decision eligible for independent medical review, a certification from the member's provider indicating that an imminent and serious threat to the health of the member exists and that the proposed therapy would be significantly less effective if not promptly initiated.

- How to File for an Independent Medical Review: The request for an independent medical review must be filed with DMHC within *180 calendar days* of California Health & Wellness Plan's written response to the member's grievance.
  - If the member, the member's provider or California Health & Wellness Plan fails to submit supporting documentation, the application will still be accepted.
  - Requests for extensions or late applications are approved if inadequate notice of the IMR process or the member's medical circumstances impaired timely submission of a request.
  - An application is not eligible for an independent medical review if the member's complaint has previously been submitted and reviewed by DMHC. Exceptions may be approved if the application for independent medical review includes medical records and a statement from the member's provider demonstrating significant changes in the member's medical condition or in medical therapies available have occurred since DMHC's disposition of the complaint. For more information on how to file for an independent medical review, please use the following link to the California Health & Wellness Plan website: IMR.
- Notification: DMHC notifies the member and California Health & Wellness Plan if an application for independent medical review has been accepted within:
  - 7 calendar days of receipt of a routine request; or
  - 48 hours for an expedited review.

The notification identifies the independent medical review organization, whether the review is expedited or routine, and if any other information is needed. California Health & Wellness Plan receives a copy of the member's application for an independent medical review.

- Required Information: After California Health & Wellness Plan is notified of the independent medical review application, California Health & Wellness Plan provides all information related to the disputed health care service, the member's grievance and California Health & Wellness Plan's determination, including:
  - Copies of all correspondence;

- A complete copy of the medical records used in making the original decision (additional copies for each reviewer);
- A copy of the cover page of the Evidence of Coverage and complete pages with the referenced sections highlighted, if the Evidence of Coverage was referenced in California Health & Wellness Plan's resolution of the member's grievance; and
- California Health & Wellness Plan's response to any additional issues raised in the member's independent medical review application.

California Health & Wellness Plan promptly provides the member with a list of all documents submitted as part of the independent medical review, along with information on how to request additional copies.

Additional Information: California Health & Wellness Plan is responsible for providing additional information:

- Any medical records or other relevant matters not available at the time of DMHC's initial notification, or that result from the member's on-going medical care or treatment for the medical condition or disease under review. Information will be forwarded as soon as possible upon receipt by California Health & Wellness Plan, not to exceed:
  - Routine cases: five business days
  - Expedited cases: one calendar day
  - Additional medical records or other information requested by the independent medical review organization will be sent within:
  - Routine cases: five business days
  - Expedited cases: one calendar day

When a request associated with an expedited review involves materials not in the possession of California Health & Wellness Plan or its providers, California Health & Wellness Plan immediately notifies the member and the member's provider by phone or facsimile to identify and request the necessary information, followed by written notification.

DMHC will contact the member or member's representative if additional information is needed.

- Determination of Need for an Independent Medical Review: DMHC reviews the information submitted and determines whether the member is eligible for an independent medical review. DMHC considers all information received, the member's medical condition and the disputed health care service when making the determination.

  If DMHC decides not to refer the case for an independent medical review, the request is then considered a complaint or grievance.

  DMHC then advises the member or the member's representative and California Health & Wellness Plan of its determination.

- Disposition: Each assigned review issues a separate written analysis of the case, explaining:
    - The determination
    - How the determination relates to the member's medical condition and history, medical records, etc., and references to the specific medical and scientific evidence, as applicable
    - The risks and benefits considered, if any

DMHC, the member or the member's representative may withdraw a case from the independent medical review at any time. California Health & Wellness Plan may withdraw the case from the review system by providing the disputed health care service, subject to the concurrence of the member.

Continuation of Services During an Appeal or State Fair Hearing

Overview: Under certain conditions, California Health & Wellness Plan continues providing previously authorized services that have been denied, suspended or reduced by California Health & Wellness Plan while a member's appeal or State Fair Hearing regarding such services is still pending. Members and providers who have questions about the continuation of such services should contact California Health & Wellness Plan at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

When Continuation of Services Applies: California Health & Wellness Plan continues a member's services if all of the following conditions apply:

- The member filed the appeal in a timely manner, meaning on or before the later of the following:
    - Within ten calendar days of the date on the notice of action, or
    - By the intended effective date of California Health & Wellness Plan's intended action
- The action involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorized period has not expired
- The member requests extension of benefits

What Happens If Services are Continued: If California Health & Wellness Plan continues or reinstates the member's services while an appeal or State Fair Hearing is pending, California Health & Wellness Plan and its providers continue furnishing the services until one of the following occurs:

- The member withdraws the request for an appeal or State Fair Hearing;
- Ten calendar days pass after California Health & Wellness Plan mails the notice providing the resolution of the appeal against the member, unless the member, within the 10 calendar day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
- The State Fair Hearing officer renders a decision that is adverse to the member; or
- The member's authorization expires or the member reaches his/her authorized service limits.

Service Outcome If State Fair Hearing Decision Favors Member: If the final resolution of a State Fair Hearing favors the member, the following steps apply:

- If Services Were Not Furnished: If services were not furnished while the State Fair Hearing was pending, and the State Fair Hearing resolution reverses California Health & Wellness's decision to deny, limit or delay services, California Health & Wellness Plan will authorize or provide the disputed services as quickly as the member's health condition requires.

- If Services Were Furnished: If services were furnished while the State Fair Hearing was pending, and the State Fair Hearing resolution reverses California Health & Wellness Plan's decision to deny, limit or delay services, California Health & Wellness Plan will pay for disputed services in accordance with State policy and regulations.

CHAPTER 18: QUALITY IMPROVEMENT

Overview

California Health & Wellness Plan is committed to continuous, measurable improvement in the delivery of quality health care for its members. California Health & Wellness Plan's culture, systems and processes are structured around its mission to continuously monitor performance in order to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QI) Program uses a systematic approach to monitor, analyze, evaluate and improve the delivery of healthcare for its members, including those with disabilities. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Each year, California Health & Wellness Plan communicates to its providers a summary of QI activities, including: areas measured, outcomes and findings, and interventions implemented to improve the quality of care and service delivered to its members. California Health & Wellness Plan may distribute QI related information through regular mail, e-mail, fax, and the Web or mobile devices. The organization mails the information to members and practitioners who do not have fax, e-mail or Internet access.

All providers who contract with California Health & Wellness Plan are required to:

- Cooperate with California Health & Wellness Plan in conducting all QI activities as requested. Cooperation includes the collection and evaluation of data, and participation in the California Health & Wellness Plan's QI programs.
- Maintain the confidentiality of member information and records.
- Allow California Health & Wellness Plan to use performance data in its reviews of quality and outcomes.

Note: California Health & Wellness Plan is subject to various statutory, regulatory and accreditation requirements, and must ensure that all agreements comply with any such mandates. Accreditation from the National Committee for Quality Assurance (NCQA) is critical to both the health plan and network providers, and ensures that we meet the highest possible standards of excellence and care.

One of the requirements of NCQA is that California Health & Wellness Plan may use practitioner performance data for quality improvement activities. Therefore, California Health & Wellness Plan contract templates have been updated with the following language:

> *Provider agrees to cooperate with quality management and improvement (QI) activities; maintain the confidentiality of member information and records pursuant to this agreement; and allow California Health & Wellness Plan Plan to use provider's performance data.*

Through its QI program and contract with its network providers, California Health & Wellness Plan notifies its providers that they may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

California Health & Wellness Plan encourages its providers to engage with the QI program and participate on its QI Committee subcommittees, which are described later in this chapter. Provider engagement helps the QI program to actively leverage the clinical experience and knowledge of the providers in the communities that California Health & Wellness Plan serves.

Providers interested in participating on a subcommittee of the QI Committee should contact California Health & Wellness Plan at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). For more information about the QI program, please also visit the Quality section of www.cahealthwellness.com by using the following link: quality program.

QI Program Structure

The California Health & Wellness Plan board of directors has the ultimate authority and accountability for overseeing the quality of care and services provided to members. The Board oversees the Quality Improvement (QI) Program and has established various committees and ad-hoc committees to monitor and support the QI Program.

Physician and other provider representatives, along with the executive leadership team of California Health & Wellness Plan, drive the Quality Improvement Committee (QIC). The QIC is accountable to the Board. The purpose of the QIC is to provide for the oversight, monitoring and assessment of the appropriateness of care, and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring. This includes the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the quality improvement (QI), utilization management (UM), and credentialing programs.

The QIC is supported by various subcommittees, which may include the following:

- Utilization Management Committee, which includes provider participation;
- HEDIS Steering Committee, which may utilize provider champions to drive improvements;
- Provider Advisory Board, which includes provider participation;
- Joint Operations Meetings;
- Credentialing and Peer Review Committee, which includes provider participation; and
- Pharmacy & Therapeutics Committee, which includes provider participation.

Provider Involvement

California Health & Wellness Plan actively encourages providers to participate in its QI Program. Please consider volunteering to serve, or agreeing to serve if asked, on a California Health & Wellness Plan QI Committee. Contact your Provider Network Specialist or the Chief Medical Director at California Health & Wellness Plan by calling (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) to express your interest. California Health & Wellness Plan especially encourages PCP, specialty, and Pediatrician, OB/GYN provider participation, as well as participation by providers serving Seniors and Persons with Disabilities (SPD) on key quality committees.

Providers who participate on a QI Committee help California Health & Wellness Plan to:

- Recommend policy decisions
- Analyze and evaluate results of QI activities
- Plan, design, implement and review the QI Program and processes
- Identify needed actions or interventions
- Re-measures compliance following interventions

California Health & Wellness Plan also encourages provider engagement through participation in its Provider/Facility Advisory committees. If you are interested in participation in a committee please contract Provider Services Department or your Provider Network Specialist at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QI Program is comprehensive and addresses both the quality of clinical care and service provided to the California Health & Wellness Plan members. The QI Program is designed to meet the needs of our culturally, linguistically, and disability diverse membership, serving all members, including those with complex health needs.

California Health & Wellness Plan primary QI Program goal is to improve members' health status through a variety of meaningful quality improvement activities. These activities are implemented across all care settings and aimed at improving quality of care and services delivered.

The QI Program monitors the following:

- Establishment of and compliance with preventive health guidelines
- Establishment of and compliance with clinical practice guidelines

- Acute and chronic care management
- Provider network adequacy and capacity (access to care and availability of practitioners)
- Selection and retention of providers (credentialing and re-credentialing)
- Behavioral healthcare (within benefits)
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over-utilization of services
- Employee and provider cultural competency
- Cultural, Linguistic, and Disability Access Program requirements, including the accuracy of provider language capability disclosure forms and attestations
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Department performance and service
- Patient safety
- Quality of care and adherence to guidelines, measured through HEDIS measures

Patient Safety and Quality of Care

Patient safety is a key focus of the California Health & Wellness Plan QI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan, but is supported primarily through identification of potential and/or actual quality of care events.

Anyone can refer a potential quality of care issue when concern arises from an act or behavior that:

- May be detrimental to the quality of patient care or patient safety;
- Does not comply with evidence-based standard practices of care; or
- Signals a potential sentinel event, up to and including death of a member.

Please contact your Provider Network Specialist or the QI Department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) to report a quality of care issue.

The QI Program description states how the organization works to improve the safety of clinical care and services provided to its members. California Health & Wellness Plan may use performance data from QI activities conducted for other elements to determine safety initiatives to address for this element. Initiatives may focus on members, practitioners or providers.

Performance Improvement Process

The California Health & Wellness Plan QIC reviews and adopts an annual QI Program and Work Plan based on Medi-Cal managed care industry standards.

The QI Work Plan and process addresses:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Members' experience

The QI Work Plan addresses our diverse membership and includes objectives to:

- Promote health care equity in clinical areas
- Improve cultural, linguistic, and disability responsiveness in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Foster California Health & Wellness Plan and provider compliance with cultural, linguistic, and disability access requirements
- Improve other areas of needs that California Health & Wellness Plan deems appropriate

Examples of care or services that California Health & Wellness Plan monitors with respect to its network include:

- Access to care
- Appointment wait times
- Availability of practitioners
- Practitioner capacity
- Turn-around-times for UM decisions
- Telephone wait times
- Access to preventive services such as cervical cancer screenings and breast cancer screenings
- Medication management trends
- Use of antibiotics
- Continuity and coordination of care

California Health & Wellness Plan communicates activities and outcomes of its QI Program to both members and providers through the member newsletter, provider newsletter and the California Health & Wellness Plan web Portal at www.cahealthwellness.com.

At any time, California Health & Wellness Plan providers may request additional information on the health plan programs including a description of the QI Program and a report on California Health & Wellness Plan progress in meeting the QI Program goals by contacting the Quality Improvement department.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows for comparison across health plans. HEDIS gives health care

purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the California State Medi-Cal contract.

As both the state of California and the Federal government move toward a healthcare industry that is driven by quality, HEDIS rates are becoming increasingly important, not only to health plans, but to the individual provider as well. California purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: using administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Examples of measures typically calculated using administrative data include rates for the following services: annual mammogram, annual Chlamydia screening, the appropriate treatment of asthma, antidepressant medication management rates, access to primary care provider (PCP) services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of a member's medical records to obtain data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (use the following link to access HEDIS reference guide brochure with more information on reducing HEDIS medical record reviews: HEDIS guides). Examples of measures typically requiring medical record review include rates for the following services: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

California Health & Wellness Plan will either contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf or will utilize California Health & Wellness Plan in-house employees to complete the MRR. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, a medical record review representative may contact your office if any of your patients are selected in the HEDIS samples. ***If contacted, California Health & Wellness Plan requests your office's prompt cooperation with the representative so that California Health & Wellness Plan can fulfill its regulatory and accreditation obligations***.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor has signed a HIPAA compliant Business Associate Agreement with California Health & Wellness Plan, which allows it to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS data

  If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will reduce the number of medical record reviews required for HEDIS rate calculation
- Check to see that chart documentation reflects all services provided
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Health Improvement Incentive Program

California Health & Wellness Plan (CHWP) offers incentive programs to encourage members to access HEDIS related preventive health care services. Eligible members will be notified of available incentives.

Provider Satisfaction Survey

California Health & Wellness Plan conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with its services such as claims, communications, utilization management, and provider services. A contracted vendor conducts the survey. The vendor randomly selects survey participants, meeting specific requirements outlined by California Health & Wellness Plan, and the participants are kept anonymous. We encourage providers to respond in a timely manner to the survey, as the results are analyzed and used as a basis for forming provider related quality improvement initiatives. In the future, California Health & Wellness Plan plans to make available the results of the provider satisfaction survey on its website.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is mandated as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Clinical Practice Guidelines

California Health & Wellness Plan clinical and quality programs are based on evidence-based preventive health and clinical practice guidelines. When appropriate, California Health & Wellness Plan adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. California Health & Wellness Plan providers are expected to follow these guidelines, and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. The following list provides a sample of clinical practice guidelines adopted by California Health & Wellness Plan:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations
- Behavioral Health clinical practice guidelines are developed by our BH plan partner and adopted by California Health & Wellness Plan

For links to the most current version of the guidelines adopted by California Health & Wellness Plan, visit our website at www.cahealthwellness.com.

Health Education Programs

California Health & Wellness Plan (CHWP) Health Education Department educates members on how to improve their health. They also educate on the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

The following interventions and resources are available at no cost to CHWP Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers can

get more information by calling the toll-free Health Education Information Line at 1-800 804-6074. Members are directed to the appropriate service or resource based on their needs. Telephone and website-based services are available 24 hours a day, seven days a week. CHWP will provide required member informing materials in threshold languages and/or alternative formats.

Weight Management

Nutrition and weight control education resources are available upon request.

Disease Management Programs

Medi-Cal members with asthma, back pain, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, and heart failure are enrolled into Disease Management programs to help them control their condition. Members receive educational resources with unlimited 24-hour access to a nurse who can help address their medical concerns. High-risk members also receive nurse initiated outbound calls to help them manage their conditions.

Diabetes Prevention Program

Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.

Start Smart for Your Baby

Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High-risk pregnancies receive additional case management services.

Tobacco Cessation Program

Kick It California (formerly California Smokers' Helpline) is a tobacco cessation program available to CHWP members. The program offers specialized services for teens, pregnant smokers, individuals who chew tobacco and e-cigarette users, and extends information on how to help a friend or family member quit tobacco use. Telephonic coaching is available in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese), and text programs may be obtained in English or Spanish. Members can learn more by calling Kick It California at 800-300-8086, or online at www.kickitca.org.

CHWP will cover tobacco cessation counseling for at least two separate quit attempts per year, without prior authorization, and with no mandatory break between quit attempts. Non-pregnant adult members are eligible for a 90-day regimen of any Food and Drug Administration- (FDA-) approved tobacco cessation medication. This includes over-the-counter medications with a prescription from the provider. At least one FDA-approved medication will be made available without prior authorization. Members may request a referral to group counseling by calling the Health Education

Department at 800-804-6074.

Digital Health Education

Teens from age 13 and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information. The interventions also encourage members in accessing timely preventive health care services.

CHWP also offers myStrength. This is a personalized website and mobile application that helps members deal with depression, anxiety, stress, substance use, pain management, and insomnia.

Member Resources

Community Health Fairs

CHWP participates in health fairs and community events to promote health awareness to members and the community. CHWP representatives provide presentations and/or health education materials at these events.

Health Education Materials

Members or parents of youth members may order health education materials on topics, such as asthma, healthy eating, diabetes, hypertension, and more. These materials are available in English and Spanish.

Preventive Screening Guidelines

CHWP provides preventive screening guidelines to inform members of health screenings and immunization schedules for all ages. They are available in English and Spanish.

CHAPTER 19: FACILITY SITE AND MEDICAL RECORDS REVIEWS

Facility Site Review Process

The facility site review is a comprehensive evaluation of a provider's facility, administration and medical records maintenance so that a provider's facility meets certain safety, accessibility and security standards pursuant to California Department of Health Care Services (DHCS) regulations. The review and certification of Primary Care Provider (PCP) sites is required for all Med-Cal managed care plans, including California Health & Wellness Plan. California law requires that all PCP sites or facilities furnishing services to Medi-Cal eligible patients must be certified and compliant with applicable DHCS standards.

The overall facility site review process has three components:

- Facility site review
- Physical accessibility review survey
- Medical records review

Each Primary Care Provider (PCP) must have a site review conducted of the provider's office prior to being credentialed with California Health & Wellness Plan. Thereafter, the facility site review is conducted every three years. This site review includes a facility site review, a medical record review and a physical accessibility review.

Each PCP must open his or her office to a facility site review, physical accessibly review or medical record audit. Provider participation is required and is not optional. However, California Health & Wellness Plan will work in a collaborative manner to coordinate visits and minimize the impact of the review on the provider's office operations, while still meeting its regulatory and contractual requirements.

Conducting the Site Review

California Health & Wellness Plan's Quality Improvement team contacts the PCP's office to schedule an appointment date and time for the facility site review. The team faxes or mails a confirmation letter with an explanation of the review process and required documentation.

During the review, the California Health & Wellness Plan reviewer will:

- Lead the pre-review conference with the PCP or office manager to provide an overview of the process and answer any questions
- Conduct the review of the facility or office

- Develop a corrective action plan (if needed)

Following the review, the California Health & Wellness Plan reviewer will meet with the provider or office staff to:

- Review and discuss the results of the review and explain any required corrective actions
- Provide a copy of the review results and corrective action plan to the Office Manager or provider
- Educate the provider or office staff about the standards and policies
- Schedule a follow-up review for any corrective actions identified

Providers must attain a minimum score of 80% or greater in order to pass the facility site review.

Review Tools

Facility Site Review Standards: If you would like to review the Facility Site Review standards, refer to the Primary Care Provider – Site Review Standards (PDF).

Medical Record Review Standards: If you would like to see how the medical record review will be audited and scored, refer to the Primary Care Provider – Medical Record Review Standards (PDF).

Physical Accessibility Review Survey: Please use the following link to obtain the survey tool and scoring guidelines for the physical accessibility review survey: Physical Review.

Medical Record Requirements and Review

California Health & Wellness Plan reviews medical records for format, legal protocols and documented evidence of the provision of preventive care, and coordination and continuity of care services. The medical record provides legal proof that patient received care. Incomplete records or lack of documentation implies that there was a gap or failure to provide care.

Medical record requirements include the following:

- A record shall be permanent, either electronic, typewritten or legibly written in ink and shall be kept on all each unique patient accepted for treatment.
- All medical records of discharged patients shall be completed within 30 days following termination of each episode of treatment and such records shall be kept for a minimum of seven (7) years, except for minors whose records shall be kept at least until one (1) year after the minor has reached the age of 18, but in no case less than seven (7) years. This includes all records, results of diagnostics including exposed X-ray film
- All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the clinic

or any authorized officer, agent or employee of either, or any person authorized by law to make such request.

- Information contained in the medical records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.
- If a provider ceases operation, arrangements shall be made for the safe preservation of the members' medical records. The provider who ceases operation must notify both California Health & Wellness Plan and the DHCS at least 48 hours before cessation of operation. To notify California Health & Wellness Plan, please contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the (877) 658-0305 number). For DHCS, please refer to the DHCS website at http://www.dhcs.ca.gov.
- California Health & Wellness Plan and the DHCS shall be informed within 48 hours, in writing, by the licensee whenever patient medical records are defaced or destroyed before termination of the required retention period. Notification shall be in writing and addressed to your Provider Network Specialist at:

California Health & Wellness Plan
4191 East Commerce Way
Sacramento, CA 95834

- If the ownership of a provider's practice changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide California Health & Wellness Plan and DHCS with written documentation. The written documentation can be emailed to CHWP_Contracting@cahealthwellness.com, faxed to 855-463-4107 or sent via regular mail to:

California Health & Wellness Plan
Attention: Contracting
4191 East Commerce Way
Sacramento, CA 95834

The written documentation should state the following:

- The new licensee shall have custody of the members' medical records and these records shall be available to the former licensee, the new licensee and other authorized persons; or
- The current licensee has made other arrangements for the safe preservation and the location of the members' medical records, and that they are available to both the new and former licensees and other authorized persons.

- All medical record entries shall be dated and be authenticated with the name, professional title, and classification of the person making the entry.
- Members' medical records shall be stored so as to be protected against loss, destruction or unauthorized use.
- Member medical records shall be filed in an easily accessible manner in the clinic.
    - Storage of records shall provide for prompt retrieval when needed for continuity of care.
    - Prior approval of California Health & Wellness Plan and DHCS is required for storage of inactive medical records away from the facility premises.
- The medical record shall be the property of the facility and shall be maintained for the benefit of the member, medical care team and clinic and shall not be removed from the clinic, except for storage purposes after termination of services.
- Providers must delegate an individual to be responsible for the securing and maintaining medical records at each site.
- The medical record must reflect all aspects of patient care, including ancillary services, and at a minimum includes the following:
    - Member identification on each page; personal/biographical data in the record
    - The member's preferred language (if other than English) and disability access needs prominently noted in the record, as well as the request or refusal of language/interpretation/disability access services
    - For member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
    - The record shall contain a problem list, a complete record of immunizations and medical maintenance or preventive services rendered.
    - Allergies and adverse reactions must be prominently noted in the record.
    - All informed consent documentation, including the human sterilization consent procedures.
    - All reports of emergency care provided (directly by the provider or through an emergency room) and the discharge summaries for all hospital admissions.
    - Consultations, referrals, specialists' pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
    - For medical records of adults, documentation of whether the individual has been informed of their rights to make decisions concerning medical care; to have an advance directive; and if an Advance Directive or a Durable Power of Attorney for Medical Care has been executed.

- A complete medical record must be maintained for each member for five years from the end of the fiscal year in which the contract with California Health & Wellness Plan expires or is terminated.
- All medical records must be available for inspection or examination by California Health & Wellness Plan, Department of Health Care Services, the United States Department of Health and Human Services, the California Department of Justice or the Comptroller General of the United States or their duly authorized representatives upon their request.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the member or a member's legal guardian or authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Providers and community mental health programs must obtain written consent from the member to release information to coordinate care regarding primary care and mental health services or substance abuse services or both.

Medical Records Transfer for New Members

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within 10 business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All primary care providers are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned California Health & Wellness Plan members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers or providers, then this should also be noted in the medical record.

Medical Records Audits

California Health & Wellness Plan will conduct random medical record audits as part of its Quality Improvement Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services, also may be assessed during a medical record audit. California Health & Wellness Plan may provide written notice prior to conducting a medical record review.

Right to Audit and Access Records, including Electronic Medical Records (EMR)

Access to Records and Audits by Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records when CHWP or its designated representative requests access to them in order to audit, inspect, review, perform chart reviews, and duplicate such records.

If performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When CHWP requests access to EMR, the provider will grant CHWP access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to CHWP for this access.

CHAPTER 20: REGULATORY REQUIREMENTS AND COMPLIANCE

Fraud, Waste, and Abuse Program

To support the proper stewardship of Medi-Cal resources, California Health & Wellness Plan takes the detection, investigation, and prosecution of fraud and abuse very seriously and has established a fraud, waste and abuse (FWA) program. This program is required under California law and by California Health & Wellness Plan's contract with the California Department of Health Care Services (DHCS). California Health & Wellness Plan successfully operates its FWA program in partnership with the Special Investigations Unit (SIU) of California Health & Wellness Plan's parent company, Centene Corporation (Centene).

Under the FWA program, California Health & Wellness Plan, with our corporate SIU team of analysts, investigators and clinicians, performs front and back-end audits to monitor network compliance with billing requirements. California Health & Wellness Plan uses sophisticated code editing software to perform systematic audits during the claims payment process. California Health & Wellness Plan uses these audits to identify the following practices:

- Unbundling of codes
- Up-coding services
- Overutilization
- Add-on codes billed without a primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

If California Health & Wellness Plan uncovers any of the foregoing patterns, or other patterns, California Health & Wellness Plan will send a written communication to the provider detailing these findings. California Health & Wellness Plan's policy is first to provide education on proper billing practices. If the pattern persists after this first step, California Health & Wellness Plan will take other steps, which will be communicated to a provider, including:

- More stringent utilization review (prepayment review)
- Recoupment of previously paid monies

- Where necessary and required under California Health & Wellness Plan's DHCS contract, reporting of suspected fraud and/or abuse to the DHCS and Department of Justice (DOJ) Bureau of Medi-Cal Fraud
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call OIG's Hotline at (800) HHS-TIPS ((800) 447-8477), the Medi-Cal Program Integrity Unit (PIU), or California Health &Wellness' anonymous and confidential FWA hotline at 1-866-685-8664. California Health & Wellness Plan and Centene take all reports of potential fraud, waste, and/or abuse very seriously and investigate all reported issues.

Please Note: Due to the evolving nature of fraudulent, wasteful and abusive billing, California Health & Wellness Plan and Centene may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.

Authority and Responsibility

The California Health & Wellness Plan Vice President of Compliance is responsible for the FWA program. California Health & Wellness Plan is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

Providers must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

Delegated providers

Delegated providers are required to have policies and procedures to detect and deter FWA, including a compliance program as defined in Title 42 CFR section 438.608(a). Delegated providers must comply with all applicable state and federal laws and regulations, including state and federal false claims acts.

Delegated providers must report any suspected case of FWA to California Health & Wellness Plan within 10 calendar days through the FWA hotline at 866-685-8664. Additionally, if a delegated provider receives information about a change in circumstances that may affect a member's eligibility (e.g., a change in residence or income or the death of a member) they must promptly contact the California Health & Wellness Plan at 877-658-0305.

Delegation Oversight will monitor and evaluate your compliance to all requirements through:

- Annual Compliance audit
    - Review of Compliance program policies and procedures including:
        - Compliance program description (requirements defined in Title 42 CFR section 438.608(a))
        - Mechanisms for detection and prevention of FWA
        - Training program for employees and providers
        - Plan for routine internal monitoring
        - Disciplinary guidelines for non-compliance
    - Proof of process execution (meeting minutes, staff interviews, logs, etc.)
    - Evidence of routine monitoring
- Additional activities as identified

Confidentiality of Medical Records

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. Written authorization from the member or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the health plan.

Network providers agree to maintain the confidentiality of member information and information contained in a member's medical records according to the Health Information Privacy and Accountability Act (HIPAA) standards. The HIPAA prohibits a provider from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority. A provider may only release such information as permitted by applicable federal, state and local laws and to the extent that the release is:

- Necessary to other providers and the health plan related to treatment, payment or health care operations; or
- Upon the member’s signed and written consent.

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

About HIPAA Privacy

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires California Health & Wellness Plan and its providers to protect the security and privacy of its members' Protected Health Information (PHI). The Act provides California Health & Wellness Plan members with certain privacy rights, including the right to file a privacy complaint.

PHI is any individually identifiable health information, including demographic information. PHI includes a member's name, address, phone number, medical information, social security number, CIN number, date of birth, financial information, etc.

California Health & Wellness Plan supports its providers' efforts to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, California Health & Wellness Plan and its providers need to work together to comply with HIPAA requirements in terms of protecting patient privacy rights, safeguarding PHI and providing patients with access to their own PHI upon request.

Security

The medical record must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration or destruction of the record. Information must be accessible only to authorized personnel within the provider's office, California Health & Wellness Plan, DHCS, or to persons authorized through a legal instrument. Office personnel must protect information about individual patient conditions or other related information so that it is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.

Storage and Maintenance

Providers must secure active medical records so that they are inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic record keeping system procedures shall be in place to preserve patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Providers must have security systems in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to keep recorded input from being altered.

Availability of Medical Records

The medical records system must allow for prompt retrieval of each record when the member comes in for services. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice.
- Facilitates an accurate system for follow-up treatment.

- Permits effective professional medical review and medical audit processes.

Medical records must be legible, signed and dated. Providers must furnish a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request. Confidentiality of and access to medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit California Health & Wellness Plan and representatives of DHCS to review members' medical records for the purposes of:

- Monitoring the provider's compliance with medical record standards.
- Capturing information for clinical studies or HEDIS.
- Monitoring quality.
- For any other reason.

Confidentiality of Medical Information

Sensitive services are defined as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924-6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

Effective July 1, 2022, Assembly Bill 1184 amends the Confidentiality of Medical Information Act to require health care plans to take additional steps to protect the confidentiality of a subscriber's or enrollee's medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

These steps include:

- A protected individual (member) is not required to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care.
- Not disclose a member's medical information related to sensitive health care services to the primary subscriber or other enrollees, unless the member's authorization is present.
- Notify the subscriber and enrollees that they may request confidential communications and how to make the request. This information must be provided to "enrollees" at initial enrollment and annually.
- Respond to confidential communications requests within:
    - 7 calendar days of receipt via electronic or phone request, or

    - 14 calendar days of receipt by first-class mail.
- Communications (written, verbal or electronic) regarding a member's receipt of sensitive services should be directed to the member's designated mailing address, email address, or phone number.
- Confidential communication includes:
    - Bills and attempts to collect payment.
    - A notice of adverse benefits determinations.
    - An explanation of benefits notice.
    - A plan's request for additional information regarding a claim.
    - A notice of a contested claim.
    - The name and address of a provider, description of services provided, and other information related to a visit.
    - Any written, oral, or electronic communication from a plan that contains protected health information.

Misrouted PHI

Providers are required to review all member information received from California Health & Wellness Plan so that no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about members that are not treated by a specific provider. PHI can be misrouted to providers by mail, fax, email, or electronic Remittance Advice. Providers must inform California Health & Wellness Plan immediately upon receipt of any misrouted PHI from the health plan. Providers must destroy or safeguard the PHI for as long as it is retained. Providers are not permitted to misuse or re-disclose misrouted PHI. If providers cannot destroy or safeguard misrouted PHI, they should contact California Health & Wellness Plan's Provider Services Department at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

Reporting a Breach of PHI

A breach is an unauthorized disclosure of Protected Health Information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that is reasonably believed to have been acquired by an unauthorized person. A breach may be paper or electronic.

Some examples of a breach include, but are not limited to:

- Sending or releasing member's PHI to an unauthorized person(s); and
- Misplacing or losing any electronic devices (e.g., thumb drive, laptop) that contain PHI.

If a provider detects a breach of PHI by California Health & Wellness Plan, a delegated entity or contractor, the provider should notify California Health & Wellness Plan immediately upon discovery. To report a breach, call California Health & Wellness Plan's Provider Services Department at (877)

658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). If a provider becomes aware of any other breach of a California Health & Wellness Plan member's PHI, it is critical that the provider immediately report the breach to California Health & Wellness Plan.

Advance Directives

California Health & Wellness Plan is committed to making its members aware of and able to avail themselves of their rights to execute advance directives. California Health & Wellness Plan is equally committed to making its providers and provider staff aware of their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to California Health & Wellness Plan members must help adult members 18 years of age and older receive information on advance directives and understand their right to execute advance directives. Providers must document such information in the permanent medical record.

California Health & Wellness Plan recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the Member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record.
- An advance directive should be included as a part of the member's medical record and include mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. If possible, a copy of the advance directive should be collected and placed in members' chart. Any such discussion should be documented in the medical record.

Financial Statements

California Health & Wellness Plan (CHWP) monitors and evaluates the financial viability of its delegated and capitated participating providers and maintains adequate procedures to ensure providers' reports and financial information confirm each provider is financially solvent (section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR)).

All providers with a capitated *Provider Participation Agreement (PPA)* are required to submit to CHWP their annual financial statements 150 days after the close of the Independent Practice Association (IPA)'s or hospital's fiscal year, and their quarterly financial updates, prepared by the provider organization and reflecting year-to-date activity, within 45 business days after the close of the calendar quarter or most recent quarter, if provider's fiscal year is different from a calendar year. The financial statements should be sent to the Finance Oversight Department via email at financeoversight-pa@healthnet.com.

Additionally, IPAs are required to submit their annual and quarterly financial statements to the DMHC (sections 1300.75.4, 1300.75.4.2, 1300.75.4.7, 1300.75.4.8, and 1300.76 of Title 28 of the California Code of Regulations (CCR)). If an IPA reports deficiencies in any of the five grading criteria listed below, the IPA must submit a self-initiated corrective action plan (CAP) proposal in an electronic format to DMHC and CHWP (section 1300.75.4.8 of Title 28 of the CCR). The grading criteria are:

- tangible net equity (TNE): must be positive
- working capital: must be positive
- cash-to-claims ratio: 0.75
- claims timeliness percentage: 95%
- incurred but not reported (IBNR) methodology, both documented and used in estimation of IBNR liabilities: three months

CHWP is required by the DMHC to follow up on late filings of the financial surveys by IPAs (section 1300.75.4.5 of Title 28 of the CCR). As soon as the IPA files with the DMHC, the IPA must immediately submit the confirmation of the filing that can be downloaded from the DMHC website to the Finance Oversight Department.

IPAs' and hospitals' financial statement packets should include the following items:

- Signed California Health & Wellness Plan financial certification form (for quarterly unaudited financials only)
- DMHC quarterly and/or annual financial survey report forms as detailed in subsection 1300.75.4.2(b) and (c) of Title 28 of the California Code of Regulations (CCR) including:
  - a balance sheet
  - an income statement
  - a statement of cash flow
  - a statement of net worth
  - cash and cash equivalent
  - receivables and payables
  - risk pool and other incentives
  - claims aging
  - notes to financial statements
  - enrollment information
  - mergers, acquisitions and discontinued operations
  - the incurred but not reported (IBNR) methodology, and

- administrative expenses
- footnote disclosures (for annual audited financial survey)
- For nonprofit entities, refer to subsection 1300.75.4.2(b) and (c) of the California Code of Regulations for additional requirements.

IPAs and hospitals must also ensure compliance with CHWP's financial solvency standard benchmarks and related contractual requirements to make sure their financial status is stable and not deteriorating over time. If the IPAs and hospitals fail to meet the financial solvency standards, and it is determined by CHWP that a CAP is needed, the IPAs and hospitals must submit a CAP within 30 days from the date of request. Below are the 14 financial solvency review standard benchmarks that must be met:

Provider Type	**Category**	**Standard**
IPA, Hospital	Working Capital	Must be positive
IPA, Hospital	Tangible Net Equity	Must be positive
IPA	Required Tangible Net Equity	Refer to 1300.76(c)(1) of Title 28 of CCR
IPA	Cash to Claims Ratio	= or > 0.75
IPA, Hospital	Current Ratio	= or > 1.0
IPA, Hospital	Quick Ratio	= or > 1.0
IPA, Hospital	Cash to Payable Ratio	= or > 0.50
IPA, Hospital	Profit Margin Ratio	> 0.00
IPA	Medical Loss Ratio	= or < 0.85
IPA, Hospital	Debt-to-Equity Ratio	= or < 1.0
IPA, Hospital	Accounts Receivable Turnover	= or > 11.81
IPA, Hospital	Average Days to Collect	= or < 30 days
IPA	Average Claims Liability	between 2.5 & 3.5 months
IPA	General and Administrative Expenses	= or < 0.15
Hospital	Total Operating Expense	= or < 1.0
IPA, Hospital	Total Z-Score	= or > 1.81

APPENDICES

I. Common Causes for Upfront Rejections

II. Common Causes of Claim Processing Delays and Denials

III. Common EOP Denial Codes

IV. Instructions for Supplemental Information CMS-1500 (8/05) Form, Shaded Field 24a-G

V. Common HIPAA Compliant EDI Rejection Codes

VI. Claim Form Instructions

VII. Forms

Appendix I: Common Causes of Upfront Rejections

Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or the claim is hand written

- **Member Date of Birth** is missing
- **Member Name or Identification Number** is missing
- **Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number** is missing
- **Attending Provider information missing or invalid from Loop 2310A on Institutional claims**
- **Date of Service is not prior to the received date of the claim (future date of service)**
- **Date of Service or Date Span i**s missing from required fields
    - Example: "Statement From" or "Service From" dates
- **Type of Bill is missing or i**nvalid (Inpatient/Outpatient Facility Claims – UB-04, field 4)
- **Diagnosis Code** is missing, invalid, or incomplete
- **Service Line Detail** is missing or invalid
- **Date of Service is prior to member's effective date**
- **Admission Type** is missing or invalid (Inpatient/Outpatient Facility Claims – UB-04, field 14)
- **Patient Status** is missing or invalid (Inpatient/Outpatient Facility Claims – UB-04, field 17)
- **Occurrence Code/Date** is missing or invalid (Inpatient/Outpatient Facility Claims – UB-04, field 31-34)
- **Revenue Code** is missing or invalid (Inpatient/Outpatient Facility Claims – UB-04, field 42)
- **CPT/Procedure Code** is missing or invalid
- **Incorrect Form Type** used

Appendix II: Common Causes of claims Processing Delays and Denials

Diagnosis Code is not to the highest level specificity required

Procedure or **Modifier Codes** entered are missing or invalid

Explanation of Benefits (EOB) from the primary insurer is missing or incomplete

Third Party Liability (TPL) information is missing or incomplete

Member ID is missing or invalid

Place of Service Code is missing or invalid

Provider TIN and NPI does not match

Revenue Code is missing or invalid

Dates of Service span do not match the listed days/units

Tax Identification Number (TIN) is missing or invalid

NDC Code is missing for drug codes or invalid

Future Dates of service cannot be billed

Taxonomy Codes are required and need to match the NPI billed

Appendix III: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENTS SEX
EX09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENTS AGE
EX10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENTS SEX
EX14	DENY: THE DATE OF BIRTH FOLLOWS THE DATE OF SERVICE
EX17	DENY: REQUESTED INFORMATION WAS NOT PROVIDED
EX18	DENY: DUPLICATE CLAIM SERVICE
EX1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
EX1L	DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION
EX28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
EX29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
EX35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
EX46	DENY: THIS SERVICE IS NOT COVERED
EX4B	DENY: SERVICE NOT REIMBURSABLE IN LOCATION BILLED
EX4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT
EX4a	DENY: ADMITTING DIAGNOSIS MISSING OR INVALID
EX4b	DENY: DIAGNOSIS CODE 1 MISSING OR INVALID
EX4c	DENY: DIAGNOSIS CODE 2 MISSING OR INVALID
EX4d	DENY: DIAGNOSIS CODE 3 MISSING OR INVALID
EX4e	DENY: DIAGNOSIS CODE 4 MISSING OR INVALID
EX4f	DENY: DIAGNOSIS CODE 5 MISSING OR INVALID
EX4g	DENY: DIAGNOSIS CODE 6 MISSING OR INVALID
EX4h	DENY: DIAGNOSIS CODE 7 MISSING OR INVALID
EX4i	DENY: DIAGNOSIS CODE 8 MISSING OR INVALID
EX4j	DENY: DIAGNOSIS CODE 9 MISSING OR INVALID
EX4k	DENY: DIAGNOSIS CODE 10 MISSING OR INVALID
EX4l	DENY: DIAGNOSIS CODE 11 MISSING OR INVALID
EX4m	DENY: DIAGNOSIS CODE 12 MISSING OR INVALID

EX4n	DENY: DIAGNOSIS CODE 13 MISSING OR INVALID
EX4o	DENY: DIAGNOSIS CODE 14 MISSING OR INVALID
EX4p	DENY: DIAGNOSIS CODE 15 MISSING OR INVALID
EX50	DENY: NOT A MCO COVERED BENEFIT
EX51	DENY: PLEASE RESUBMIT CLAIM TO THE STATE FOR CONSIDERATION
EX57	DENY: CODE WAS DENIED BY CODE AUDITING SOFTWARE
EX58	DENY: CODE REPLACED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION
EX5N	DENY: NDC UNIT OF MEASURE QUALIFIER OR QUANTITY MISSING OR INVALID
EX6N	DENY: NDC NUMBER MISSING OR INVALID
EX6a	DENY: ICD-9 or ICD-10 PROC CODE 1 MISSING OR INVALID
EX6b	DENY: ICD-9 or ICD-10 PROC CODE 2 MISSING OR INVALID
EX6c	DENY: ICD-9 or ICD-10 PROC CODE 3 MISSING OR INVALID
EX6d	DENY: ICD-9 or ICD-10 PROC CODE 4 MISSING OR INVALID
EX6e	DENY: ICD-9 or ICD-10 PROC CODE 5 MISSING OR INVALID
EX6f	DENY: ICD-9 or ICD-10 PROC CODE 6 MISSING OR INVALID
EX6g	DENY: ICD-9 or ICD-10 PROC CODE 7 MISSING OR INVALID
EX6h	DENY: ICD-9 or ICD-10 PROC CODE 8 MISSING OR INVALID
EX6i	DENY: ICD-9 or ICD-10 PROC CODE 9 MISSING OR INVALID
EX6j	DENY: ICD-9 or ICD-10 PROC CODE 10 MISSING OR INVALID
EX6k	DENY: ICD-9 or ICD-10 PROC CODE 11 MISSING OR INVALID
EX6l	DENY: ICD-9 or ICD-10 PROC CODE 12 MISSING OR INVALID
EX86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
EX99	DENY: MISC UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION REPORT
EX9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS
EX9N	CLAIM CANNOT BE PROCESSED WITHOUT OPERATIVE REPORT
EXA1	DENY: AUTHORIZATION NOT ON FILE
EXBG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
EXBI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
EXCF	DENY: WAITING FOR CONSENT FORM
EXDS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
EXDW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT

EXDX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE
EXE4	DENY: INVALID OR MISSING ADMISSION SOURCE
EXE6	DENY: DISCHARGE HOUR, ADMIT DATE/HOUR MISSING/INVALID ON INPAT CLAIM
EXE8	DENY: INVALID OR MISSING ADMIT TYPE
EXEC	DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
EXHQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY WITH CONSENT FORM
EXHW	DENY: PAYMENT INCLUDED IN THE HIGHER INTENSITY CODE BILLED
EXI9	DENY: DIAGNOSIS MISSING OR INVALID
EXIM	DENY: MODIFIER MISSING OR INVALID
EXL6	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB
EXLO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT
EXMG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
EXMQ	DENY: MEMBER NAME NUMBER DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT
EXN5	DENY: NDC MISSING/INVALID OR NOT APPROPRIATE FOR PROCEDURE
EXNT	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
EXRX	DENY: SUBMIT TO PHARMACY VENDOR FOR PROCESSING
EXU1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
EXVI	GLOBAL FEE PAID
EXZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
EXx3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
EXx4	PROCEDURE CODE ICD-9 OR ICD-10 CODE INCONSISTENT WITH MEMBERS GENDER
EXx5	PROCEDURE CODE CONFLICTS WITH MEMBERS AGE
EXx6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
EXx7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
EXx8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
EXx9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
EXxa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
EXxb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA

EXxc	PROCEDURE DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
EXxd	PROCEDURE CODE APPENDED WITH BILATERAL 50 MODIFIER
EXxe	PROCEDURE CODE INCONSISTENT WITH MEMBERS AGE
EXxf	MAXIMUM ALLOWANCE EXCEEDED
EXxh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED
EXxp	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
EXxq	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
EXye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS

Appendix IV: Instructions For Supplemental Information

CMS-1500 (8/05) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (8/05) form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- UPN for contracted medical supplies

The following qualifiers are to be used when reporting these services.

7 Anesthesia information

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

N4 National Drug Codes (NDC)

The following qualifiers are to be used when reporting NDC units:

F2 International Unit

GR Gram

ME Milligram

ML Milliliter

UN Unit

VP Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)

Universal product Number

HI Health Care Industry Bar Code (HIBC)

EO GTIN EAN/UCC

UP Consumer Package Code U.P.C.

EN European Article Number (EAN)

UK U.P.C./EAN Shipping Container Code

ON Customer Order Number

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in a single shaded claim line IF the information is related to the un-shaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information.

Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code.

Examples:

Anesthesia

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7Begin 1315 End 1445 Time 90 minutes										
									NPI	

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached										
									NPI	

Vendor Product Number- HIBCC

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA123ABC7D9E1F										
									NPI	

Product Number Health Care Uniform Code Council – GTIN

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
OZ01234567891112										
									NPI	

Universal Product Number (UPN) for contracted disposable incontinence and medical supplies

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
UK10610075077233			UN0000002000							
04 01 09	12		A4399			23 00	2		NPI	
ON30003175507			UN0000002000							
04 01 09	12		A4367			15 00	2		NPI	

NDC Format

An NDC number on a drug container consists of digits in a 5-4-2 format. Hyphens (-) separate the number into three segments. Although an NDC on a drug container may have fewer than 11 digits, an 11-digit number must be entered on the claim. An NDC entered on the claim must have five digits in the first segment, four digits in the second segment, and two digits in the last segment. The first five digits of an NDC identify the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The remaining digits are assigned by the manufacturer and identify the specific product and package size. Placeholder zeros must be entered on the claim wherever digits are needed to complete a segment.

Here are examples of entering placeholder zeroes on the claim:

Package NDC	Zero Fill	11-digit NDC
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2	(00002-0022-02)	00002002202

National Drug Code (NDC)

The National Drug Code (NDC) is required to be billed on claim forms for drugs administered by physicians, outpatient hospitals, and dialysis centers. This section contains information on when and how to report an NDC code. NDC codes must be reported when California Health & Wellness Plan is the secondary or tertiary payer as well.

When to Report the NDC code on the CMS1500 and UB04 Claim Forms:

1. Physician Administered Drugs - when billing for drugs using the J-code HCPCS, the claims must include the J-code HCPCS, a valid 11-digit NDC, as well as the quantity administered using the correct unit of measure. This does not include physician-administered drugs for inpatient services, immunizations and radiopharmaceuticals.
2. Outpatient Hospital Claims - for bill types 131 and 135, when billing for revenue codes 0250, 0251, 0252, 0257, 0258, 0259 and 0637, claims must include the J-code HCPCS, a valid 11-digit NDC, as well as the quantity administered using the correct unit of measure.
3. Dialysis Claims - for bill types 721, when billing for revenue codes 0250, claims must include a valid 11-digit NDC, as well as the quantity administered using the correct unit of measure.

How to Report the NDC code

I. Professional Claims

The NDC number reported must be the actual NDC number on the package or container from which the medication was administered.

837P (Electronic submission)

For electronic claims that are submitted using the 837P, the NDC codes must be included in Loop 2410 data element LIN03 of the LIN segment. The quantity must be in Loop 2410

CTP04 and the unit of measure (UOM) code in Loop 2410 CTP05-01. The unit price must be populated in Loop 2410 CTP03 but can be entered with a value of zero.

CMS1500 (Paper submission)

1. For paper claims, the NDC code, unit of measure and quantity must be entered in the shaded area of box 24A. The NDC number submitted must be the actual NDC number on the package or container from which the medication was administered.
2. Begin by entering the qualifier N4 immediately followed by the 11-digit NDC number. The NDC codes must be in the 5-4-2 format required by HIPAA guidelines; do not report hyphens. It may be necessary to pad NDC numbers with zeroes in order to report eleven digits.
3. Next enter the two digit unit of measurement qualifier immediately followed by the numeric quantity administered to the patient. The Unit Quantity with a floating decimal for fractional units is limited to three (3) digits after the decimal point. Do not use a decimal or comma if the whole number is entered. Do not zero fill, leave remaining positions blank.
4. A maximum of seven (7) positions to the left of the floating decimal may be reported.
5. When reporting a whole number, do not key the floating decimal.
6. When reporting fractional units, you must enter the decimal as part of the entry.

Sample NDC:
Whole Number Unit:
N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 5 6 7
Fractional Unit:
N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 . 5 6 7

Below are the measurement qualifiers when reporting NDC units:

Measurement Qualifiers
F2 International Unit
GR Gram
ML Milliliter
UN Units

Reporting Multiple NDCs on a Professional Claim

If submitting via paper and the drug administered comprises more than one ingredient, each NDC must be represented in the service lines. The HCPCS code should be repeated as necessary to cover each unique NDC code. Enter a KP modifier for the first drug of a multiple drug formulation and enter a modifier of KQ to represent the second or subsequent drug formulations.

If submitting electronically and the drug administered comprises more than one ingredient, the compound drug should be reported by repeating the LIN and CTP segments in the 2410 drug identification loop.

II. Facility Claims

- Outpatient Hospital Claims - NDC code is required on outpatient hospital claims (type of bill 131/135) when reporting revenue codes within series 025X and revenue code 0637.
- Freestanding Dialysis Claims - NDC is required when reporting the revenue code 0250 with bill type 721.

837I (Electronic Submission)

For electronic claims that are submitted using the 837I, the NDC codes must be included in Loop 2410 data element LIN03 of the LIN segment. The quantity must be in Loop 2410 CTP04 and the unit of measure (UOM) code in Loop 2410 CTP05-01. The unit price must be populated in Loop 2410 CTP03 but can be entered with a value of zero.

UB04 (Paper Submission)

Facility claims that are submitted via paper should be submitted using the following format:

1. In Field 43 report the NDC qualifier of "N4" in the first two positions, left justified. The NDC number submitted must be the actual NDC number on the package or container from which the medication was administered.
2. Begin by entering the qualifier N4 immediately followed by the 11-digit NDC number. The NDC codes must be in the 5-4-2 format required by HIPAA guidelines, do not enter hyphens. It may be necessary to pad NDC numbers with zeroes in order to report eleven digits.
3. Next enter the two-digit unit of measurement qualifier immediately followed by the numeric quantity administered to the patient. The Unit Quantity with a floating decimal for fractional units is limited to three (3) digits to the right of the decimal point.
4. A maximum of seven (7) positions to the left of the floating decimal may be reported.
5. When reporting a whole number, do not key the floating decimal.
6. When reporting fractional units, you must enter the decimal as part of the entry.

Sample NDC:
Whole Number Unit:
N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 5 6 7

Fractional Unit:
N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 . 5 6 7

Below are the measurement qualifiers when reporting NDC units:

Measurement Qualifiers
F2 International Unit
GR Gram
ML Milliliter
UN Units

Reporting Multiple NDC's on a Facility Claim:

1. You may report multiple line items of revenue codes and associated NDC numbers as follows:
2. Each line item must reflect the revenue code 0250 with the appropriate HCPCS;
3. Each line item must reflect a valid NDC per the NDC format; and
4. Each NDC reported must be unique or the revenue code line item will deny as a duplicate against the revenue code and NDC line item that matched it.

If submitting electronically, and the drug administered is comprised of more than one ingredient, the compound drug should be reported by repeating the LIN and CTP segments in the 2410 drug identification loop.

Reporting Compound Drugs on a Facility Claim:
When reporting compound drugs, a maximum of five (5) lines are allowed and should be reported in the following manner:

1. List the most expensive ingredient first, followed by the rest of the ingredients.
2. On the first line for the compound drug, report the revenue code (0250), the valid NDC per the NDC format, the appropriate HCPCS for the drug that is administered, the total number of units administered for all drugs in the compound and the total charge for all of the drugs that are in the compound.
3. For each subsequent line, report only the NDC and the appropriate HCPCS related to the compound drug.
4. If one line for the compound drug denies, the entire compound drug will deny.

National Drug Code (NDC) FAQs: NDCs and the 340B Drug Pricing Program

Providers are encouraged to inquire with their authorized drug purchasing agent to determine if drugs are purchased under the 340B program.

The amount listed on the Medi-Cal claim line should be equal to the total of the acquisition cost **plus** the dispensing/administration fee. It is not necessary to enter separate amounts on the claim.

Medi-Cal requires the NDC information for audit purposes to verify that the 340B entities are charging the appropriate amount. As directed by the Health Resources and Services Administration (HRSA) *Federal Register's* "Entity Guidelines" (Vol 59. No. 92, May 13, 1994, page 25112): "If a drug is purchased by or on behalf of a Medicaid beneficiary, the amount billed may not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veteran's Health Care Act of 1992, plus a reasonable dispensing fee established by the State Medicaid agency." Since 340B prices are set by NDC, state and federal auditors will use the NDC when evaluating whether or not a 340B entity is complying with HRSA rules.

Medi-Cal is using the UD modifier with the appropriate HCPCS Level I, II or III code, but claims will still require the N4 product qualifier **and** 11-digit NDC number for audit purposes. Providers that purchase drugs under the 340B program are required to bill Medi-Cal at the provider's acquisition cost and the state-established dispensing/administration fee. In order for it to be verified when audited, the NDC number is required on the claim.

The claim line for a physician administered drug without an NDC will be denied, regardless of the presence of the UD modifier.

Appendix V: Common HIPAA Compliant EDI Rejection Codes

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see California Health & Wellness Plan's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

CODE	DESCRIPTION
ERROR_ID	**ERROR_DESC**
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS;Prv not valid at DOS
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc

36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc

73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006
75	Invalid Unit
76	Original claim number required
81	Invalid Unit; Invalid Prv
83	Invalid Unit; Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
77	INVALID CLAIM TYPE
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
ZZ	Claim not processed
37	Invalid or future date.
37	Invalid or future date.
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
HP	ICD10 is mandated for this date of service.
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
90	Invalid or Missing Modifier

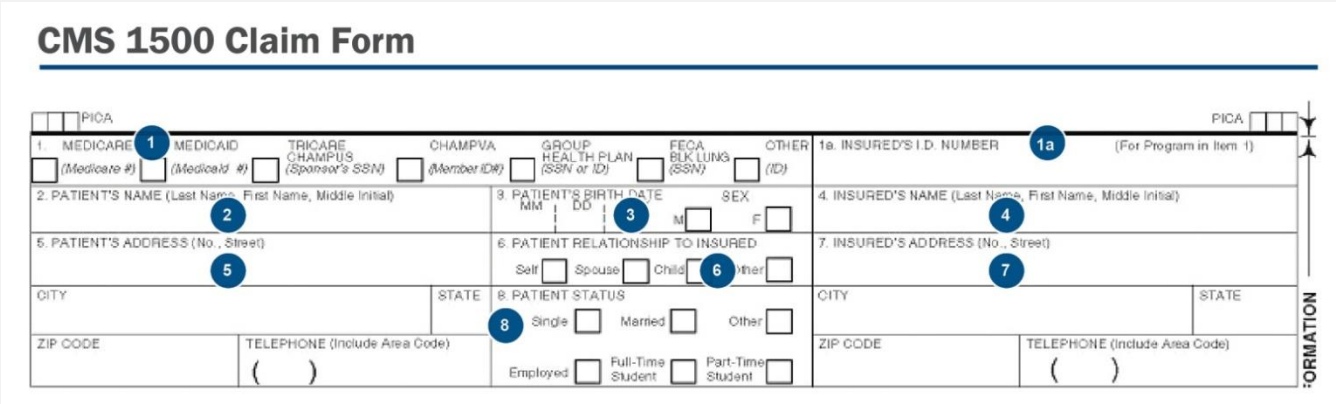
Appendix VI: Claims Form Instructions[1]

Billing Guide for a CMS-1500 and CMS UB-04

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

Completing a CMS 1500 Form

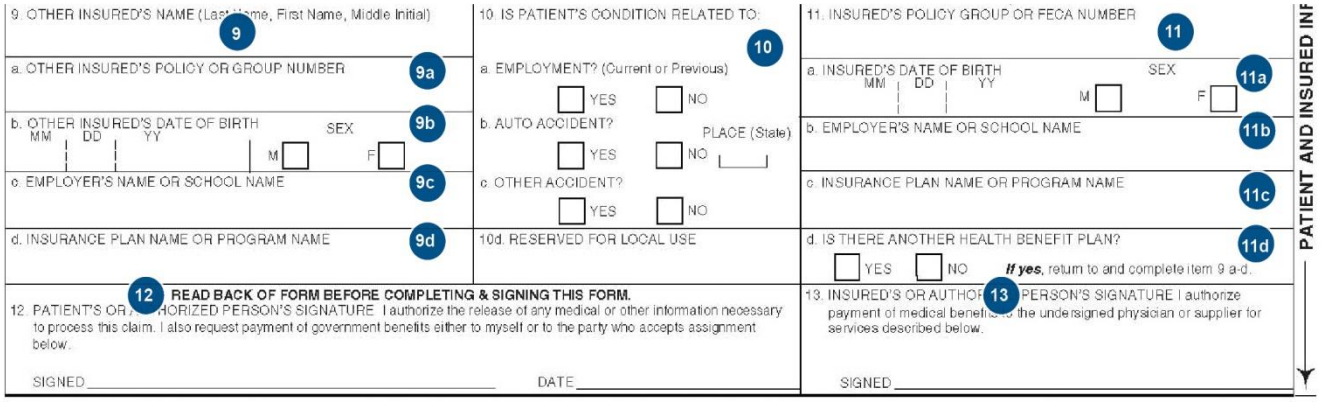
FIELD#	Field Description	Instruction or Comments	Required or Conditional
			
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter "X" in the box noted Medicaid (Medicaid #).	R
1a	INSURED I.D. NUMBER	The 9-digit (8 numeric characters and 1 alpha character) Medicaid identification number on the member's California Health & Wellness Plan I.D. card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's California Health & Wellness Plan I.D. card. Do not use nicknames.	R

1

FIELD#	Field Description	Instruction or Comments	Required or Conditional
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of (MM|DD|YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = male F = female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's California Health & Wellness Plan I.D. card.	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 5010A1.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C

FIELD#	Field Description	Instruction or Comments	Required or Conditional
7	INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 5010A1.	Not Required
8	PATIENT STATUS		Not Required

CMS 1500 Claim Form

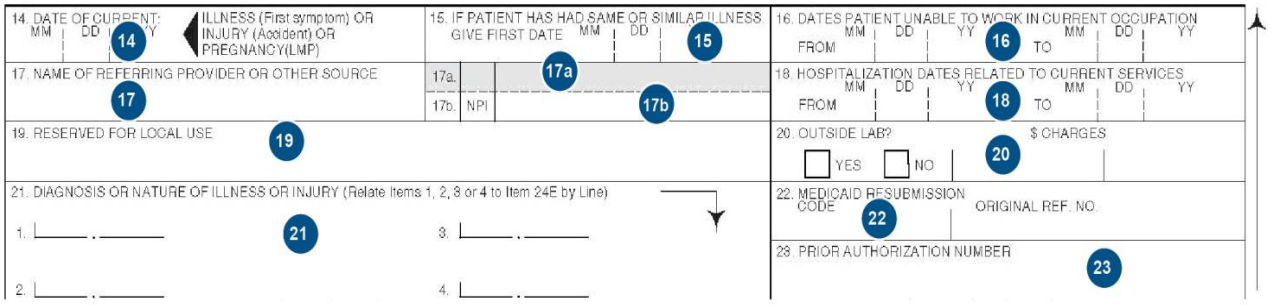


9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C

FIELD#	Field Description	Instruction or Comments	Required or Conditional
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	OTHER INSURED'S BIRTH DATE / SEX	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate sex/gender. M = male F = female for the person listed in box 9.	C
9c	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 5010A1.	C
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	RESERVED FOR LOCAL USE		Not Required
11	INSURED'S POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C
11b	EMPLOYER'S NAME OR SCHOOL NAME	REQUIRED if Employment is marked Yes in box 10a.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance Health Plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R

FIELD#	Field Description	Instruction or Comments	Required or Conditional
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	PATIENT'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required

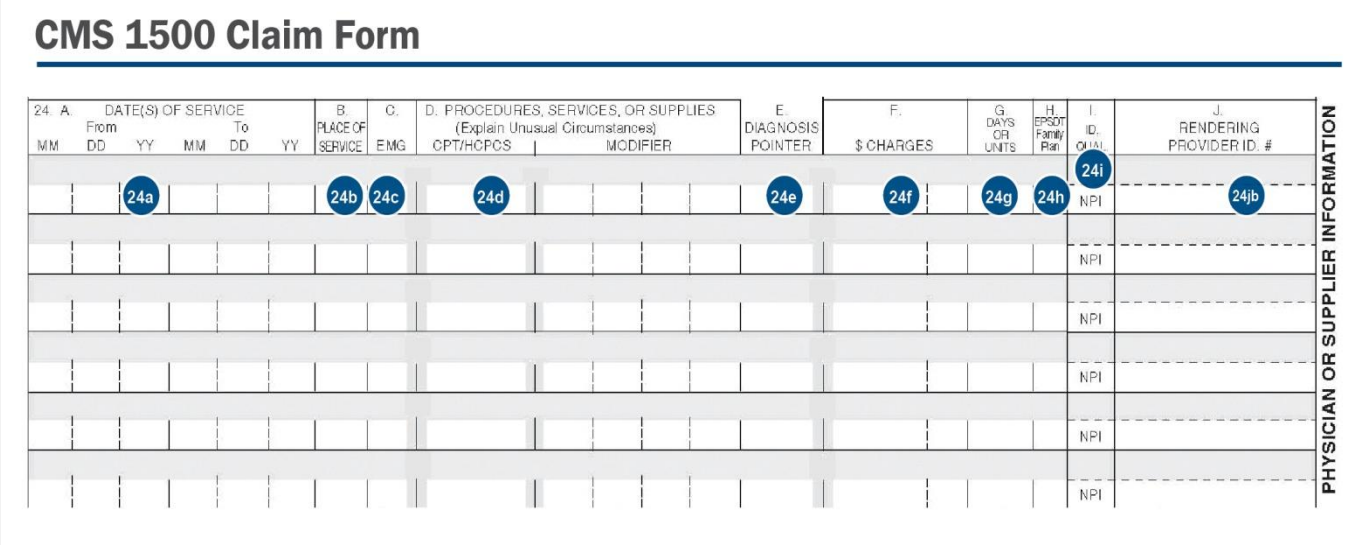
CMS 1500 Claim Form



14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date reflecting the first date of onset for the: Present illness Injury LMP (last menstrual period) if pregnant	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		Not Required
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		Not Required
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	Not Required

FIELD#	Field Description	Instruction or Comments	Required or Conditional
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE		C
20	OUTSIDE LAB / CHARGES		Not Required
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9/ICD-10 CM Volume 1 for the date of service. Diagnosis codes submitted must be valid ICD-9/ICD-10 codes for the date of service and carried out to its highest digit – 4th or“5”. "E" codes are NOT acceptable as a primary diagnosis. Note: Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “RESUBMISSION” to avoid denials for duplicate submission.	C
23	PRIOR AUTHORIZATION NUMBER	Enter the California Health & Wellness Plan authorization or referral number. Refer to the California Health & Wellness Plan Provider Manual for information on services requiring referral and/or prior authorization. When billing CLIA lab services use Box 23 to note the CLIA certification or waiver number	C

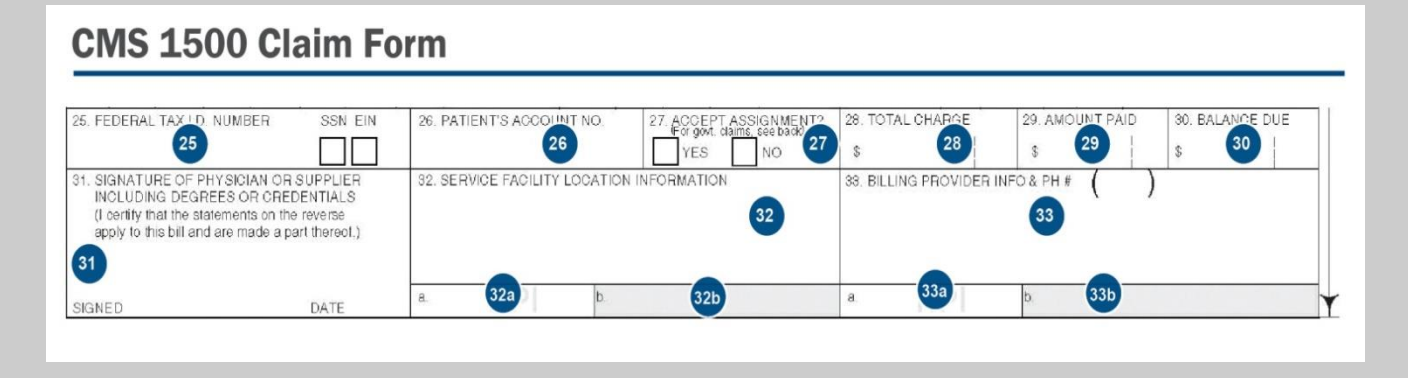
FIELD#	Field Description	Instruction or Comments	Required or Conditional



24a-j General Information		Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, CHDP qualifier, and Provider Medicaid Number. Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.	
24a-g Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC, UPN, Anesthesia Start/Stop time & duration Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. HIBCC or GTIN number/code. For detailed instructions and qualifiers refer to Appendix 4 of this Manual.	C

FIELD#	Field Description		Instruction or Comments	Required or Conditional
24a Un-shaded		DATE(S) OF SERVICE	Enter the date the service listed in 24D was performed (MM|DD|YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24b Un-shaded		PLACE OF SERVICE	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website.	R
24c Un-shaded		EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24d Un-shaded		PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24e Un-shaded		DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1, 2, 3, and 4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9/10 codes for the date of service or the claim will be rejected/denied.	R

FIELD#	Field Description	Instruction or Comments	Required or Conditional
24f Un-shaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24g Un-shaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R
24h Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24h Un-shaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	C
24i Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for Medicaid ID, if an Atypical Provider	C
24j Shaded	NON-NPI PROVIDER ID#	Enter as designated below the Medicaid ID number or taxonomy code. Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. Atypical Providers: Enter the Medicaid Provider ID number.	R
24j Un-shaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, Independent Lab, Home Health, RHC/FQHC general Medical Exam, CMHC, etc.)	R



25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	Not Required
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	R
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing California Health & Wellness Plan. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

30	BALANCE DUE	REQUIRED when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. Note: Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box #'s are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical Providers Enter the 2-character qualifier 1D (no spaces).	C

33	BILLING PROVIDER INFO & PH #	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHER ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier. Atypical Providers: Enter the Medicaid Provider ID number.	C

UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claims for reimbursement by California Health & Wellness Plan. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services and dialysis services.

Incomplete or inaccurate information will result in the claim/encounter being rejected for corrections.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

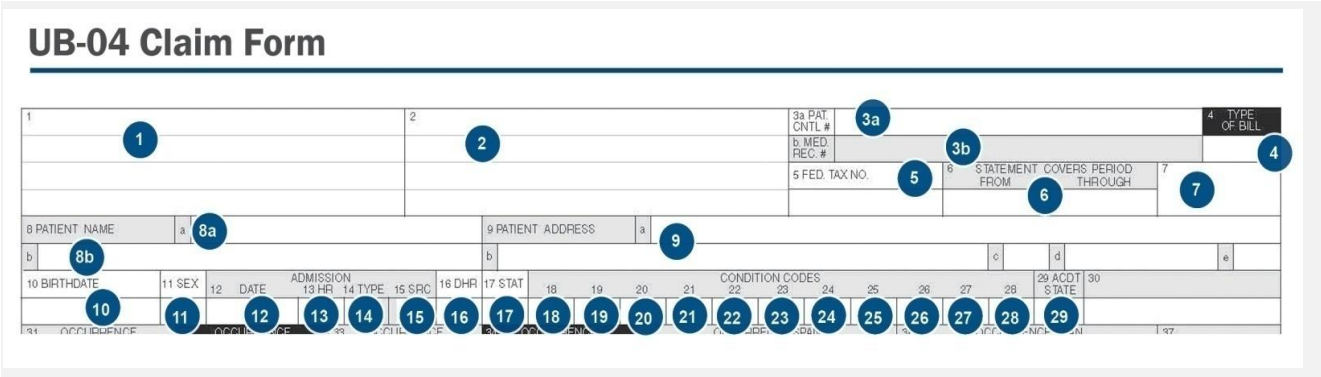
- Professional fees must be billed on a CMS 1500-claim form.

- Include the appropriate CPT code next to each revenue code.

Exceptions

Please refer to your provider contract with California Health & Wellness Plan or to the Medi-Cal Provider Manuals for Revenue Codes that do not require a CPT code.

Completing a CMS UB-04 Form



1	(UNLABELED FIELD)	Line 1: Enter the complete provider name.	R
		Line 2: Enter the complete mailing address.	
	**ALERT: Providers submitting paper claims should left-align data in this field.	Line 3: Enter the City, State, and zip+4 code (include hyphen). NOTE: the 9-digit zip (zip + 4 code) is a requirement for paper and EDI claims.	
		Line 4: Enter the area code and phone number.	
2	(UNLABELED FIELD)	Enter the Pay-To Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R

4	TYPE OF BILL	Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st digit - Indicating the type of facility. 2nd digit - Indicating the type of care 3rd digit - Indicating the billing sequence.	R
5	FED. TAX NO.	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service. (MMDDYY)	R
7	(UNLABELED FIELD)	Not Used	Not Required
8 a-b	PATIENT NAME	8a – Enter the patient's 9-digit (8 numeric characters and 1 alpha character) Medicaid identification number on the member's California Health & Wellness Plan I.D. card.	Not Required

8 a-b	PATIENT NAME	8a – Enter the patient's 13-digit Medicaid identification number on the member's California Health & Wellness Plan I.D. card.	Not Required

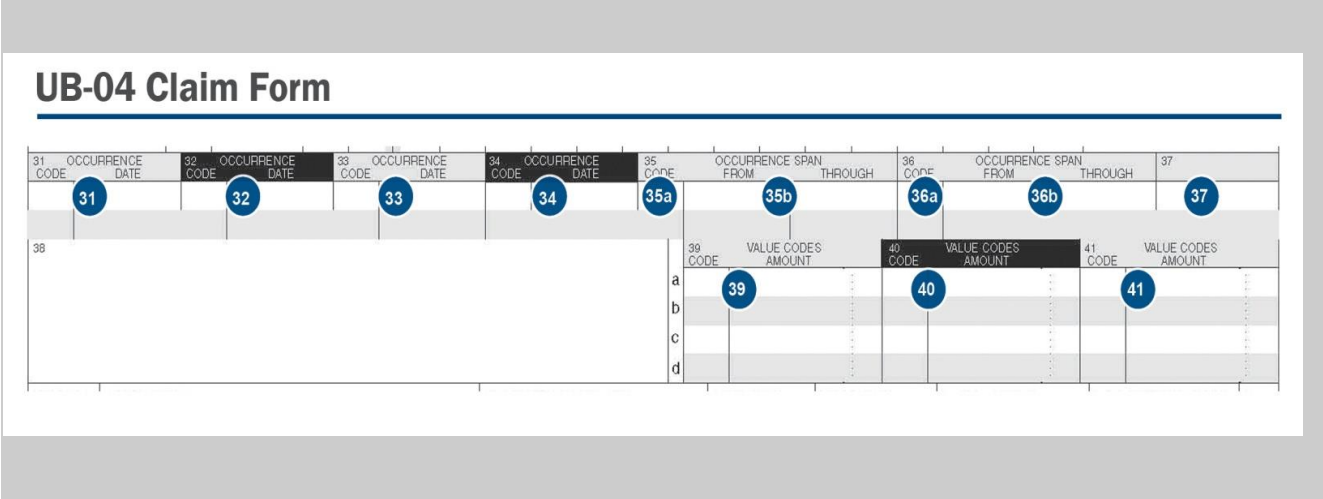
		8b – Enter the patient's last name, first name, and middle initial as it appears on the California Health & Wellness Plan Health Plan ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name e.g., McKendrick. H Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R
9 a-e	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Lined: ZIP Code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. (MMDDYY) Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require box 12 to be populated.	C (R for inpatient. Leave blank for outpatient.)
13	ADMISSION HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 12- 12:00 noon to 12 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59	C (R for inpatient. Leave blank for outpatient.)

		04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59 Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require box 12 to be populated.	
14	ADMISSION TYPE	Required for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of admission 1,2,3 or 5 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility (SNF) 6 Transfer from another health care facility 8 Court/Law enforcement	R

		9 Information not available For type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	
16	DISCHARGE HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge. 00-12:00 midnight to 12:59 12- 12:00 noon to 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient and Outpatient claims. Enter the 2-digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution	R

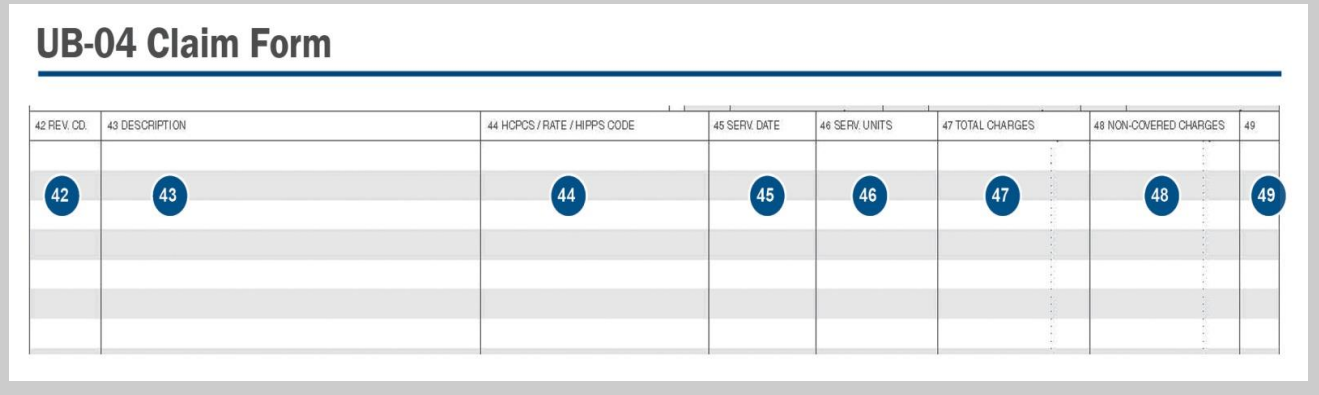
		06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital	

		66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	(UNLABELED FIELD)	Not Used	Not Required



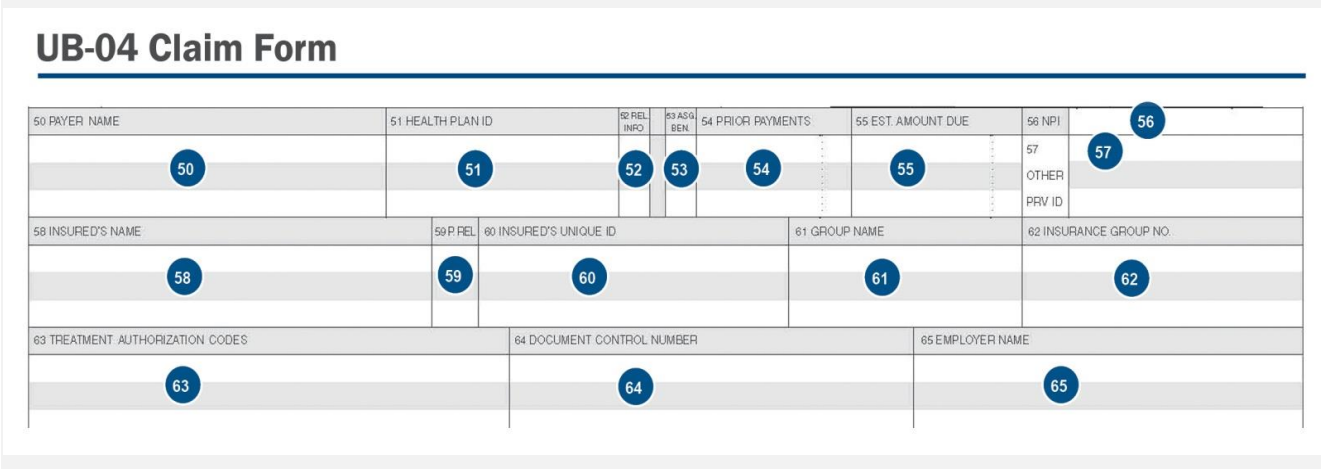
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “RESUBMISSION” to avoid denials for duplicate submission.	C

38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. Value Code 54 – **(REQUIRED)** Enter this code in the code field with the newborn birth weight in grams in the amount field (No decimals). Right justify the weight in grams to the left of the dollars/cents delimiter.	C



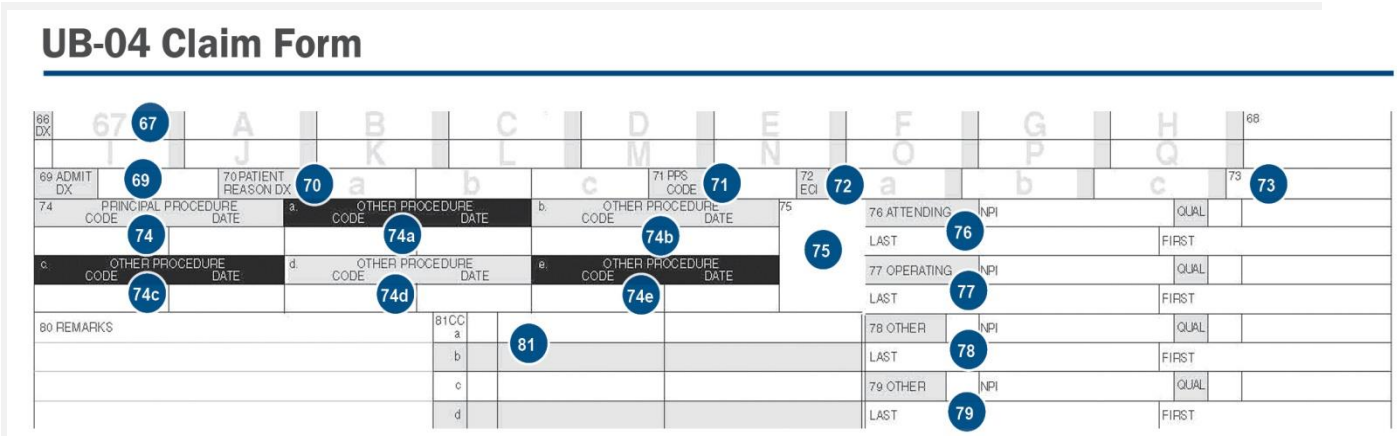
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted enter a “1” in both fields (i.e. PAGE “1” OF “1”).	R
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use a spaces, commas, dashes or the like between the CPT/HCPC and modifier(s) Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract with California Health & Wellness Plan or to the Department of Health and Hospitals Medicaid Provider Procedures Manual	C

45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required



50 A-C	PAYER	Enter the name for each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		Not Required
52 A-C	REL. INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter “Y” (yes) or “N” (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y”.	R
53	ASG. BEN.	Enter “Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid/California Health & Wellness Plan is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER or PROVIDER ID	Required: Enter provider’s 10-character NPI ID.	R
57	OTHER PROVIDER ID	a. Enter the numeric provider Medicaid identification number assigned by the Medicaid program. b. Enter the TPI number (non -NPI number) of the billing provider	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient’s name. Enter the name as last name, first name, middle initial.	R

59	PATIENT RELATIONSHIP		Not Required
60	INSURED’S UNIQUE ID	REQUIRED: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance /Medicaid ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character Document Control Number (DCN) of the paid HEALTH claim when submitting a replacement or void on the corresponding A, B, C line reflecting California Health & Wellness Plan from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of “7” (Replacement of Prior Claim) or Type of Bill Frequency of “8” (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Required



67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis code submitted must be a valid ICD-9/10 code for the date of service and carried out to its highest level of specificity. "E" and most “V” codes are NOT acceptable as a primary diagnoses. Note: Claims with missing or invalid diagnosis codes will be denied	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9 or ICD-10 codes for the date of service and carried out to its highest level of specificity. "E" and most “V” codes are **NOT** acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied. **The POA indicator** is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A-Q. In other words, report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and	C

		include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.	
68	(UNLABELED)	Not Used	Not Required
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9/10 codes for the date of service and carried out to its highest level of specificity. "E" codes and most “V” are **NOT** acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.	R
70 a,b,c	PATIENT REASON CODE	Enter the ICD-9/10-CM code that reflects the patient’s reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to its highest digit. "E" codes and most “V” are **NOT** acceptable as a primary diagnosis. **Note**: Claims with missing or invalid diagnosis codes will be denied	R
71	PPS / DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	(UNLABELED)		Not Required

74	PRINCIPAL PROCEDURE CODE / DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
		REQUIRED for EDI Submissions.	
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 or ICD-10 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9 or ICD-10 procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	(UNLABELED)		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and Name of the physician in charge of the patient care: NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code	R

		LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed: NPI: Enter the operating physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code LAST: Enter the operating physician's last name FIRST: Enter the operating physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and Name of the physician in charge of the patient care: (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial #	C

		LAST: Enter the other physician's last name. FIRST: Enter the other physician's first name.	
80	REMARKS		C
81	CC	A: Taxonomy of billing provider. Use ZZ qualifier	C

Appendix VII: Approved Modifier List

Below is a list of approved modifier codes for use in billing Medi-Cal. Modifiers not listed in this section are unacceptable for billing Medi-Cal. Please also use the following link to reference the most updated Medi-Cal Modifier List: Modifiers.

Modifier Overview

Some modifier information in this section is taken from the CPT-4 code book (Current Procedural Terminology – 4th Edition) and HCPCS code book (Healthcare Common Procedure Coding System, Level II).

Discontinued Modifiers

Medicaid programs have traditionally tailored modifiers for their state's needs. These interim (or local) modifiers are being phased out under HIPAA requirements. Refer to the list of discontinued and invalid modifiers at the end of this section.

National Correct Coding Initiative

Medi-Cal claims are subject to a set of claims processing edits that are federally mandated. The edits, controlled by the Centers for Medicare & Medicaid Services (CMS), are part of the National Correct Coding Initiative (NCCI).

Modifiers relevant to the NCCI edit methodology are designated "NCCI associated" in the following modifier list. See the Correct Coding Initiative: National section for how NCCI affects reimbursement.

Note: NCCI does not allow more than one NCCI-associated modifier on a line for Treatment Authorization Requests (TARs),

CMS-1500 claims and UB-04 claims. TARs and claims containing two or more NCCI-associated modifiers on the same line will be denied. In addition, placement of modifiers on the claim is important. An NCCI-associated modifier should not appear in the first modifier position (next to the procedure code) unless it is the only modifier on that claim line.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
22*	*Increased procedural services*	May be used with computed tomography (CT) codes when additional slices are required or a more detailed evaluation is necessary. Used by Local Educational Agency (LEA) to denote an additional 15-minute service increment rendered beyond the required initial service time. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information. Surgical: May be billed when procedures involve significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of prior surgery, marked scarring, adhesions, inflammation, or distorted anatomy, irradiation, infection, very low weight (for example, neonates and small infants less than 10 kg) and/or trauma (as documented in a recipient's medical record). Justification is required on the claim. **Anesthesia: Prone position, base units less than or equal to three units**
24* NCCI associated	Unrelated E&M service by the same physician during a postoperative period	
25* NCCI associated	Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service	
26*	Professional component	

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
27* NCCI associated	Increased procedural services	
33*	Preventive service	Not used by Medi-Cal at this time. May be appended to specific codes for Medicare/Medi-Cal dual coverage.
47*	Anesthesia by surgeon	Do not use as a modifier for anesthesia codes.
50*	Bilateral procedure	
51*	Multiple procedures	
52*	Reduced services	Surgical: For use with surgery codes 66820 – 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 – 66985. Requires "By Report" documentation. Used by LEA to denote an annual re-assessment. See *Local Educational Agency (LEA)* in the appropriate Part 2 Manual for more information. LEA does not require "By Report" documentation.
53*	Discontinued procedure	Requires "By Report" documentation.
54*	Surgical care only	
55*	Postoperative management only	
57 †	Decision for surgery	
58* NCCI associated	Staged or related procedure or service by the same physician during the postoperative period	May be used with codes 15002 – 15429 and 52601 to address subsequent part(s) of a staged procedure.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
59* **NCCI associated**	Distinct procedural service	**Used primarily** with codes 36818 – 36819 and 76816. **Also used with other codes, as appropriate, for NCCI purposes.**
62*	Two surgeons	
66*	Surgical team	
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia (to be reported by hospital outpatient department or surgical clinic, only)	To be reported by hospital outpatient department or surgical clinic only. Requires "By Report" documentation.
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia	To be reported by hospital outpatient department or surgical clinic only. Requires "By Report" documentation.
76*	Repeat procedure or service by same physician	
77*	Repeat procedure by another physician	
78* **NCCI associated**	Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period	

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
79* NCCI associated	Unrelated procedure or service by the same physician during the postoperative period	
80*	Assistant surgeon	
90*	Reference (outside) laboratory	Only specified providers may use this modifier.
91* NCCI associated	Repeat clinical diagnostic laboratory test	
99*	Multiple modifiers	Used when two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. **Do not bill 99 when billing split-billable claims without a modifier (professional and technical service component) or with modifier 26 (professional component) and TC (technical component). The claim will be denied.** Also used in special circumstances as specified by the Department of Health Care Services (DHCS). For an example, refer to the *Surgery Billing Examples: UB-04* or *Surgery Billing Examples: CMS-1500* sections in the appropriate Part 2 Manual.

* Check the CPT-4 book for guidelines in using this modifier.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
AA	**Anesthesia performed by an anesthesiologist**	
AG	Primary physician	Surgical: Used to denote a primary surgeon. In the case of multiple primary surgeons, two or more surgeons can use modifier AG for the same patient on the same date of service if the procedures are performed independently and in different specialty areas. This does not include surgical teams or surgeons performing a single procedure requiring different skills. An explanation of the clinical situation and operative reports by all surgeons involved must be included with the claim. Used by LEA to denote licensed physicians/psychiatrists. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.
AH	Clinical psychologist	Used by LEA to denote licensed psychologists, licensed educational psychologists and credentialed school psychologists. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.
AI	Principal physician of record	Allowable for all procedure codes.
AJ	Clinical social worker	Used by LEA to denote licensed clinical social workers and credentialed school social workers. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination	Use only for ophthalmology.
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD	
AZ	Physician providing a service in a dental health profession shortage area for the purpose of an electronic health record incentive payment	

* Check the CPT-4 book for guidelines in using this modifier.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
CS	Item of service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities	
DA	Oral health assessment by a licensed health professional other than a dentist	
DS	**Ambulance service origin code D (diagnostic or therapeutic site other than P or H when these are used as origin codes) with ambulance service destination code S (scene of accident or acute event)**	**Medical transport dry run**
E1 NCCI associated	Upper left, eyelid	Use modifier SC with CPT-4 code 68761 (closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery; by plug, each) to indicate use of temporary collagen punctal plugs. Modifiers E1 thru E4 are used in connection with permanent silicone punctal plugs and procedures on the eyelids.
E2 NCCI associated	Lower left, eyelid	*Same as above*
E3 NCCI associated	Upper right, eyelid	Same as above
E4 NCCI associated	Lower right, eyelid	Same as above
ET	Emergency services	
F1 NCCI associated	Left hand, second digit	

* Check the CPT-4 book for guidelines in using this modifier.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
F2 NCCI associated	Left hand, third digit	
F3 NCCI associated	Left hand, fourth digit	
F4 NCCI associated	Left hand, fifth digit	
F5 NCCI associated	Right hand, thumb	
F6 NCCI associated	Right hand, second digit	
F7 NCCI associated	Right hand, third digit	
F8 NCCI associated	Right hand, fourth digit	
F9 NCCI associated	Right hand, fifth digit	
FA NCCI associated	Left hand, thumb	

* Check the CPT-4 book for guidelines in using this modifier.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
FP	Family planning services	Add modifier to HCPCS and CPT-4 codes as appropriate: Z1032 – Z1038 + FP Z6200 – Z6500 + FP 59400 + FP 59510 + FP 59610 + FP 59618 + FP 99201 – 99215 + FP 99241 – 99245 + FP 99281 – 99285 + FP 99341 – 99353 + FP 99384 + FP 99394 + FP
GC	**Physician services provided by a resident and teaching physician**	**Add modifier to CPT-4 codes 99201 – 99499 (Evaluation and Management Services) as appropriate.**
GN	Service delivered under an outpatient speech-language pathology plan of care	Used by LEA to denote licensed speech-language pathologists and speech-language pathologists. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.

* Check the CPT-4 book for guidelines in using this modifier.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
GO	Service delivered under an outpatient occupational therapy plan of care	Used by LEA to denote registered occupational therapists. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.
GP	Service delivered under an outpatient physical therapy plan of care	Used by LEA to denote licensed physical therapists. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.
GQ	Via asynchronous telecommunications system	Used to denote store-and-forward telecommunications system.
GT	Via interactive audio and video telecommunications systems	Used to denote real-time telecommunications system.
GU	Waiver of liability statement issued as required by payer policy, routine notice	
GX	Notice of liability issued, voluntary under payer policy	
GY	Item or service statutorily excluded; does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit	Used to denote that the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) recipient with full-scope Medi-Cal has started a physician-ordered course of treatment before reaching 21 years of age and the recipient is to complete the course of the prescribed treatment; OR the recipient started a physician-ordered course of treatment before July 1, 2009 and required additional time to complete treatment after this date. GY is to be used ONLY for services exempted from the optional benefits exclusion policy. Use of GY only applies to medical/surgical care required for the treatment and the resolution of the acute episode.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
HA	Child/adolescent program	Used by pediatric subacute facility to denote that the patient is a child.
HB	Adult program, nongeriatric	Used by adult subacute facility to denote that the patient is an adult.
HN	**Ambulance service origin code H (hospital) with ambulance service destination code N (skilled nursing facility)**	**Ambulance modifier H may be used in conjunction with modifier N (H+N) to indicate transportation from an acute care hospital to a skilled nursing facility.**
HO	*Masters degree level*	Used by LEA to denote program specialists. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information.
HT	Multi-disciplinary team	Used by California Community Transition (CCT) Demonstration providers to denote CCT services.
J4	DMEPOS item subject to DMEPOS competitive bidding program that is furnished by a hospital upon discharge	Allowable but not required for all DME codes.
KC	Replacement of special power wheelchair interface	
KX	Requirements specified in the medical policy have been met	Specific required documentation on file.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
LC NCCI associated	Left circumflex coronary artery	
LD NCCI associated	Left anterior descending coronary artery	
LM †	**Left main coronary artery**	
LT NCCI associated	Left side (used to identify procedures performed on the left side of the body)	
NB	Nebulizer system, any type, FDA-cleared for use with specific drug	
NU	New equipment	Used to denote purchase of new equipment.
P1*	*A normal, healthy patient*	Used to denote anesthesia services provided to a normal, uncomplicated patient.
P3*	A patient with severe systemic disease	Used to denote anesthesia services provided to a patient with severe systemic disease.
P4*	A patient with severe systemic disease that is a constant threat to life	Used to denote anesthesia services provided to a patient with severe systemic disease that is a constant threat to life.
P5*	A moribund patient who is not expected to survive without the operation	Used to denote anesthesia services provided to a moribund patient who is not expected to survive without the operation.

* Check the CPT Book for Guidelines in using this modifier
† NCCI associated

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
PA	*Surgery, wrong body part*	Allowable for all procedure codes.
PB	*Surgery, wrong patient*	Allowable for all procedure codes.
PC	*Wrong surgery on patient*	Allowable for all procedure codes.
PI	*Positron emission tomography (PET) or PET/computed tomography (CT) to inform initial treatment strategy of tumors*	Allowable but not required for all radiology procedure codes.
PS	*PET or PET/CT to inform the subsequent treatment strategy of cancerous tumors*	Allowable but not required for all radiology procedure codes.
PT	**Colorectal cancer screening test; converted to diagnostic test or other procedure**	
QE	Prescribed amount of oxygen is less than one liter per minute (LPM)	
QF	Prescribed amount of oxygen exceeds four liters per minute (LPM) and portable oxygen is prescribed	
QG	Prescribed amount of oxygen is greater than four liters per minute (LPM)	Use this modifier if portable oxygen is NOT prescribed.

* Check the CPT Book for Guidelines in using this modifier
† NCCI associated

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	**Note:** Modifier QK will also be used when billing for the supervision of one anesthesia procedure.
QN	Ambulance service furnished directly by a provider of services	May be used in conjunction modifier HN for medical transportation, which is the combination of ambulance service origin code H (hospital) and ambulance service destination code N (skilled nursing facility).
QP	Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002 – 80019, G0058, G0059 and G0060	Used for lab codes where documentation is on file showing that the test was ordered individually.
QS	Monitored anesthesia care service	Used by California Children's Services (CCS) to denote monitored anesthesia care.
QW	CLIA waived test	Used to certify that the provider is performing testing for the procedure with the use of a specific test kit from manufacturers identified by the Centers for Medicare & Medicaid Services (CMS).
QX	CRNA service: with medical direction by a physician	
QY	**Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**	
QZ	CRNA service: without medical direction by a physician	
RA	Replacement	Used to indicate replacement vision care frames and lenses.
RB	Replacement as part of a repair	Used to indicate replacement parts during repair of Durable Medical Equipment (DME), including parts of eyeglass frames.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
RC NCCI associated	Right coronary artery	
RI †	**Ramus intermedius**	
RR	Rental	Used to indicate when DME is to be rented.
RT NCCI associated	Right side (used to identify procedures performed on the right side of the body)	
SA	Nurse practitioner rendering service in collaboration with a physician	
SB	Nurse midwife	Used when Certified Nurse Midwife service is billed by a physician, hospital outpatient department or organized outpatient clinic (not by CNM billing under his or her own provider number).
SC	Medically necessary service or supply	
SE	State and/or federally funded programs/services	
SK	Member of high-risk population (use only with codes for immunization)	
SL	*State-supplied vaccine*	Used for Vaccines For Children (VFC) program recipients through 18 years of age.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
T1 **NCCI associated**	**Left foot, second digit**	
T2 **NCCI associated**	**Left foot, third digit**	
T3 **NCCI associated**	**Left foot, fourth digit**	
T4 **NCCI associated**	**Left foot, fifth digit**	
T5 **NCCI associated**	**Right foot, great toe**	
T6 **NCCI associated**	**Right foot, second digit**	
T7 **NCCI associated**	**Right foot, third digit**	
T8 **NCCI associated**	**Right foot, fourth digit**	
T9 **NCCI associated**	**Right foot, fifth digit**	

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
TA **NCCI associated**	**Left foot, great toe**	
TC	Technical component	
TD	Registered nurse (RN)	
TE	Licensed practical nurse (LPN)/Licensed vocational nurse (LVN)	Used by LEA to denote licensed vocational nurses. See *Local Educational Agency* (LEA) in the appropriate Part 2 Manual for more information. Used by Pediatric Palliative Care Waiver Program (PPCWP) to denote licensed vocational nurses providing services to children receiving palliative care services.
TH	Obstetrical treatment/services, prenatal or postpartum	Used to denote that the service rendered is ONLY for pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy. Modifier TH can be used for up to 60 days after termination of pregnancy. TH is to be used ONLY for services exempted from the optional benefits exclusion policy.
TL	Early intervention/Individualized Family Services Plan (IFSP)	Used by LEA to denote that service is part of IFSP. See *Local Educational Agency (LEA)* in the appropriate Part 2 Manual for more information.
TM	Individualized Education Plan (IEP)	Used by LEA to denote that service is part of individualized education plan. See *Local Educational Agency (LEA)* in the appropriate Part 2 Manual for more information.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
TS	Follow-up service	Used by LEA to denote an amended re-assessment. See *Local Educational Agency (LEA)* in the appropriate Part 2 Manual for more information.
TT	Individualized service provided to more than one patient in same setting	Used by Home and Community-Based Services (HCBS) Waiver Program to denote services provided to two HCBS Nursing Facility/Acute Hospital (NF/AH) Waiver recipients who reside in the same residence. Also referred to as shared services.
TU	**Special payment rate, overtime**	**Used by medical transportation to bill for waiting time in excess of the first 15 minutes, in one-half (1/2) hour increments.**
U1	Medicaid level of care 1, as defined by each state	Used by HCBS Waiver Program to denote skilled nursing services A or B level of care. Also used with HCPCS code A4269 to indicate the type of spermicide (gel, jelly, foam, cream). See the *Family Planning* section in the appropriate Part 2 Manual or the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* Manual for details.
U2	Medicaid level of care 2, as defined by each state	Used by HCBS Waiver Program to denote skilled nursing services A or B level of care. Also used with HCPCS code A4269 to indicate the type of spermicide (suppository). See the *Family Planning* section in the appropriate Part 2 Manual or the Family PACT PPBI Manual for details.
U3	Medicaid level of care 3, as defined by each state	Used by HCBS Waiver Program to denote skilled nursing services A or B level of care. Also used with HCPCS code A4269 to indicate the type of spermicide (vaginal film). See the *Family Planning* section in the appropriate Part 2 Manual or the Family PACT PPBI Manual for details.
U4	Medicaid level of care 4, as defined by each state	Also used with HCPCS code A4269 to indicate the type of spermicide (contraceptive sponge). See the *Family Planning* section in the appropriate Part 2 Manual or the Family PACT PPBI Manual for details.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
U5	Medicaid level of care 5, as defined by each state	Used with HCPCS code J3490 to indicate emergency contraceptive pills (ulipristal acetate). See the *Family Planning* section in the appropriate Part 2 Manual or the Family PACT PPBI Manual for details.
U6	Medicaid level of care 6, as defined by each state	Used by HCBS Waiver Program to separate California Community Transitions (CCT) services from other waiver services. Used with HCPCS code J3490 to indicate emergency contraceptive pills (levonorgestrel). See the *Family Planning* section in the appropriate Part 2 Manual or the Family PACT PPBI Manual for details. Also used by Family PACT (Planning, Access, Care and Treatment) Program with HCPCS codes 99401, 99402 and 99403 to indicate Education and Counseling (E&C) services. See the Family PACT PPBI Manual for details.
U7	Medicaid level of care 7, as defined by each state	Used to denote services rendered by Physician Assistant (PA).
U8	**Medicaid level of care 8, as defined by each state**	**Used with HCPCS code J3490 to indicate medroxyprogesterone acetate for contraceptive use.**
UA	Medicaid level of care 10, as defined by each state	Used for surgical or non-general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. Also used to indicate outpatient heroin detoxification services per visit, days 1 – 7. See the *Heroin Detoxification Billing Codes* section for details.
UB	Medicaid level of care 11, as defined by each state	Used for surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. Also used to indicate outpatient heroin detoxification services per visit, days 8 – 21. See the *Heroin Detoxification Billing Codes* section for details.

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
UC	Medicaid level of care 12, as defined by each state	Used to indicate outpatient heroin detoxification services once per week, days 8 – 21 (in lieu of UB). See the *Heroin Detoxification Billing Codes* section for details.
UD	Medicaid level of care 13, as defined by each state	Used by Section 340B providers to denote services provided or drugs purchased under this program.
UJ	Services provided at night	**Used by medical transportation to indicate that services were provided between 7 p.m. and 7 a.m.**
UN	Two patients served	**Used to indicate that two patients were served in medical transportation.**
UP	Three patients served	**Used to indicate that three patients were served in medical transportation.**
UQ	Four patients served	**Used to indicate that four patients were served in medical transportation.**
UR	Five patients served	**Used to indicate that five patients were served in medical transportation.**
US	Six or more patients served	**Used to indicate that six or more patients were served in medical transportation.**
V5	Any vascular catheter (alone or with any other vascular access)	Allowable for all procedure codes.
V6	Arteriovenous graft (or other vascular access not including a vascular catheter)	Allowable for all procedure codes.
V7	Arteriovenous fistula only (in use with two needles)	Allowable for all procedure codes.
XE **NCCI Associated**	**Separate encounter: a service that is distinct because it occurred during a separate encounter**	
XP **NCCI Associated**	**Separate practitioner: a service that is distinct because it was performed by a different practitioner**	

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
XS NCCI Associated	Separate structure: a service that is distinct because it was performed on a separate organ/structure	
XU NCCI Associated	Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service	
YW	Not applicable. This is an interim (local) modifier.	Required professional experience (applies only to speech therapists and audiologists).
ZL	Not applicable. This is an interim (local) modifier.	This modifier is used to certify that initial comprehensive antepartum office visit occurred within 16 weeks of the last menstrual period (LMP) (up to and including pregnancies of 16 weeks and 0/7ths days gestation only). Used with HCPCS code Z1032 only. (Reimbursed only once during pregnancy – service limitation of once in nine months.) Use of this modifier adds $56.63 to reimbursement. Available only to Comprehensive Perinatal Services Program (CPSP) providers. For enrollment information, see *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* in the appropriate Part 2 Manual.

Discontinued and Invalid Modifiers

Below is a list of discontinued and invalid modifier codes for use in billing Medi-Cal. Modifiers listed below are no longer acceptable for billing Medi-Cal.

Discontinued/ Invalid Modifier	Discontinuation Date	Modifier Description
21	September 1, 2009	Prolonged evaluation and management services (see *Evaluation and Management [E&M]* section in the appropriate provider Manual on how to bill for prolonged E&M visits).
60	May 1, 2009	Altered surgical field. Use modifier 22.
75	May 1, 2009	Concurrent care, services rendered by more than one physician.
AF	August 1, 2005	Anesthesia complicated by total body hypothermia above 30 degrees.
AN	February 1, 2009	Physician assistant service. Replaced by HIPAA compliant modifier U7.
AS	February 1, 2009	Physician Assistant serving as first assistant in surgery under an approved supervising physician. Use HIPAA compliant modifier 80 to denote assistant surgeon.
V8	**October 1, 2012**	**Infection present. Allowable for all procedure codes.**
V9	**October 1, 2012**	**No infection present. Allowable for all procedure codes.**
Y1	November 1, 2005	Rental without sales tax (hearing aids)
Y2	November 1, 2005	Purchase or repair without sales tax (hearing aids)
Y6	November 1, 2005	Rental with sales tax (hearing aids)
Y7	November 1, 2005	Purchase, repair, mileage with sales tax (standard item, hearing aids)
YQ	November 1, 2005	Certified Nurse Midwife service (when billed by a physician, organized outpatient clinic or hospital outpatient department). Replaced by HIPAA compliant modifier SB.
YR	February 1, 2009	Certified Nurse Midwife service (multiple modifiers) (when billed by a physician, organized outpatient clinic or hospital outpatient department). Replaced by HIPAA compliant modifier 99.
YS	November 1, 2005	Nurse Practitioner service. Replaced by HIPAA compliant modifier SA.
YT	February 1, 2009	Nurse Practitioner service (multiple modifiers). Replaced by HIPAA compliant modifier 99.
YU	February 1, 2009	Physician Assistant service (multiple modifiers). Replaced by HIPAA compliant modifier 99.

YV	July 1, 2001	AIDS Waiver providers only. Administrative expenses when billed by Computer Media Claims (CMC).

Discontinued/ Invalid Modifier	Discontinuation Date	Modifier Description
Z1	**Not applicable. This is an interim (local) modifier.**	**Additional air mileage in excess of 10 percent of standard airway mileage distances. Reason for additional mileage flown must be documented on the claim or on an attachment.**
ZA	March 1, 2011	Anesthesia procedures complicated by unusual position or surgical field avoidance
ZB	March 1, 2011	Anesthesia (emergency services, healthy patient)
ZC	March 1, 2011	Anesthesia complicated by extracorporeal circulation
ZD	March 1, 2011	Emergency anesthesia (systemic disease)
ZE	March 1, 2011	Nurse anesthetist service; elective anesthesia: normal, healthy patient
ZF	March 1, 2011	Anesthesia supervision
ZG	March 1, 2011	Multiple anesthesia modifiers
ZH	March 1, 2011	Nurse anesthetist service; anesthesia special circumstances: unusual position/field avoidance
ZI	March 1, 2011	Nurse anesthetist service; anesthesia special circumstances: total body hypothermia
ZJ	March 1, 2011	Nurse anesthetist service; emergency anesthesia: normal, healthy patient
ZK	November 1, 2005	Primary Surgeon. Replaced by HIPAA compliant modifier AG.
ZM	November 1, 2010	Supplies and drugs for surgical procedures with other than general anesthesia or no anesthesia. Replaced by HIPAA compliant modifier UA.
ZN	November 1, 2010	Supplies and drugs for surgical procedures with general anesthesia. Replaced by HIPAA compliant modifier UB.

ZO	March 1, 2011	Nurse anesthetist service; anesthesia special circumstances: extracorporeal circulation

Discontinued/ Invalid Modifier	**Discontinuation Date**	**Modifier Description**
ZQ	December 30, 2013	Family planning counseling. Certifies that family planning counseling was provided during a routine non-family planning office visit. Limited to female recipients 15 – 44 years of age. Can be reimbursed once per recipient per provider in a 12-month period. (For detailed billing information, see the *Family Planning* section in the appropriate Part 2 Manual.)
ZP	March 1, 2011	Nurse anesthetist service; elective anesthesia: patient with severe systemic disease that is a constant threat to life
ZR	March 1, 2011	Nurse anesthetist service; emergency anesthesia: patient with severe systemic disease that is a constant threat to life
ZS	**August 1, 2015**	**Professional and technical component**
ZT	March 1, 2011	Nurse anesthetist service; emergency anesthesia: moribund patient who is not expected to survive without the operation
ZU	November 1, 2005	Exception modifier to 80 percent reimbursement (medical necessity requires common office procedure to be performed in outpatient setting)
ZV	November 1, 2005	Exception modifier to 80 percent reimbursement (non-hospital-compensated physician called from outside to render emergency service)
ZX	March 1, 2011	Nurse anesthetist service; emergency or elective anesthesia: patient with severe systemic disease
ZY	March 1, 2011	Nurse anesthetist service; elective anesthesia: moribund patient who is not expected to survive without the operation

Appendix VIII: Commonly Used Forms

1. Patient Consent Forms:
    a. Hysterectomy Informed Consent Form
    b. Sterilization Consent Form
2. Pharmacy Forms:
    a. Prescription Drug Authorization Request Form
3. UM Forms:
    a. Outpatient Prior Authorization Form
    b. Inpatient Prior Authorization Form
    c. CBAS Referral Form
    d. Continuity of Care Request Form
4. Billing and Claims Related Forms
    a. CMS 1500 Claim Form (HCFA)
    b. CMS 1450 (UB-04) Claim Form
    c. Provider Dispute Resolution Form
5. PCP Forms
    a. Care Management Referral Form
    b. Newborn Referral Form
    c. Notification of Pregnancy Form
6. MHN Behavioral Health Forms
    a. Single Case Agreement for Behavioral Health Services
    b. Psychological or Neuropsych Testing Authorization Request Form
    c. MHN Applied Behavioral Analysis OTR Form
    d. MHN Behavioral Health Outpatient Treatment Request Tips Sheet
    e. MHN Behavioral Health Outpatient Treatment Request Form
    f. MHN Provider Roster Listing Form
    g. MHN Provider Change Form
    h. MHN PCP Communication Form

7. Credentialing Forms
    a. California Individual Provider Data Credentialing Form
    b. Disclosure of Ownership and Control Interest Statement
    c. CAQH Provider ID Request Form
8. Grievance and Appeal Forms
    a. Member Appeal or Grievance Form
    b. Authorization to Disclose Protected Health Information
    c. DMHC Complaint Form
    d. Independent Medical Review Application
    e. Medical Records Release Form
    f. Authorized Representative Form
9. Facility Site and Medical Record Review Forms
    a. Facility Site and Medical Record Review Guidelines and Tool
    b. Physical Accessibility Review Survey