



Provider Manual

Revised July 2021



CALIFORNIA HEALTH & WELLNESS – QUICK REFERENCE GUIDE

Resource	Contact
Website	www.cahealthwellness.com
Mailing Address	California Health & Wellness 1740 Creekside Oaks Drive, Suite 200 Sacramento, CA 95833
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 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
Involve Pharmacy Solutions	Phone: (855) 330-2338 (For TTY, contact California Relay by dialing 711 and provide the 1-855-330-2338 number) FAX: (866) 399-0929 Website: www.envolvehealth.com CoverMyMeds Online Prior Auth Form: go.covermymeds.com/envolve

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
CVS Caremark – Pharmacy Network/ Claims Help Desk	Phone: 1-844-276-1398
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 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	<p>Paper Claims Submission:</p> American Specialty Health Group, Inc. Attn: Claims Department P.O. Box 509001 San Diego, CA 92150-9001
Contracting Inquiries	California Health & Wellness Attn: Contracting 1740 Creekside Oaks Drive, Suite 200 Sacramento, CA 95833
MHN – Behavioral Health Service	1-800-647-7526 option 3 for behavioral health (BH) service referrals and any general inquiry assistance related to BH services
MHN Behavioral Health Services Claims Submission Details	<p>Paper Claims Submission:</p> MHN Attn: Claims Department PO Box 14621 Lexington, KY 40512-4621
Health Information Programs	Information line: 1-800-804-6074

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CHAPTER 1: INTRODUCTION

Welcome

Welcome to California Health & Wellness. 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' 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 works to accomplish this goal by partnering with the providers who oversee the healthcare of California Health & Wellness' members.

About California Health & Wellness

California Health & Wellness 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 is focused on improving the health of our members. California Health & Wellness 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 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 invests in the communities we serve through community engagement, health education programs and partnerships. The California Health & Wellness 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 strives to improve health status, foster successful outcomes, and attain high member and provider satisfaction. California Health & Wellness' 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 complies with applicable 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:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides 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' 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 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 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

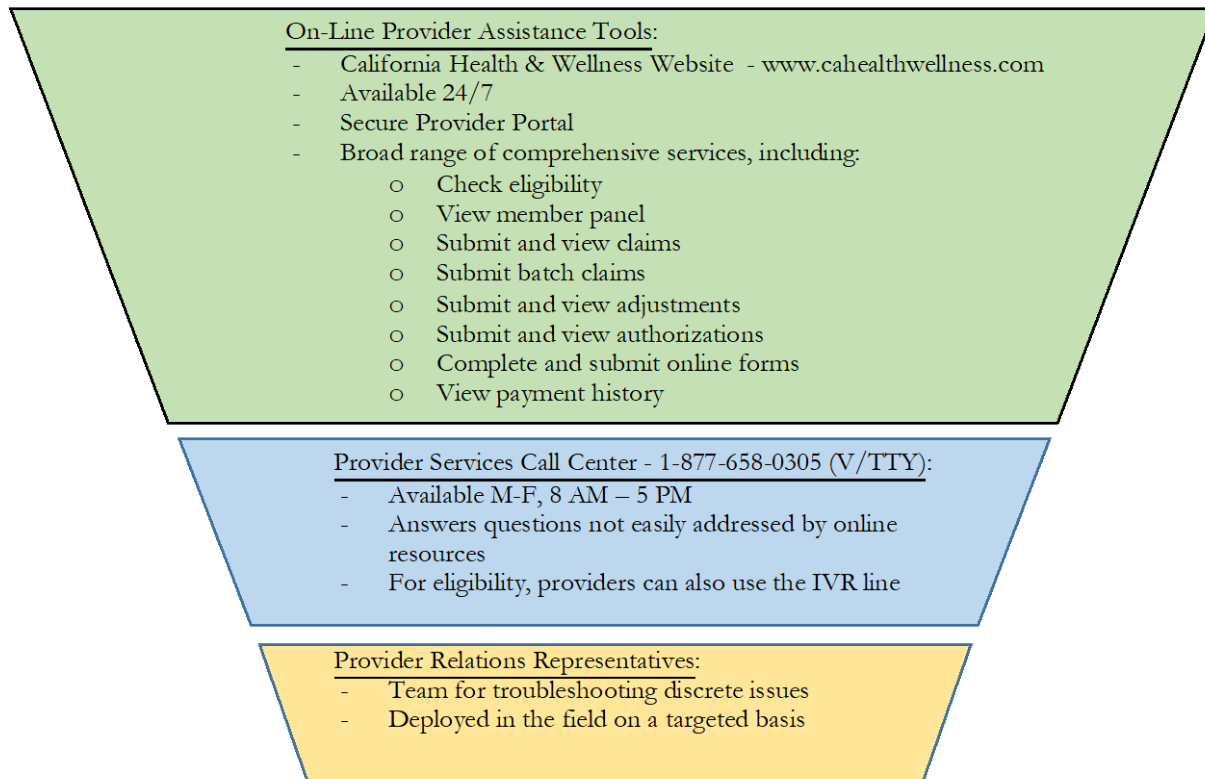
When you have questions or need assistance, we encourage you to first use the many resources that we have available for providers on the California Health & Wellness website (www.cahealthwellness.com) and on our secure Provider Portal. You will always be able to obtain assistance 24 hours, 7 days per 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 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 AM to 5 PM 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 contact information regarding specific topics.

Additionally, California Health & Wellness 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 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' 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
- Services Covered by Other Agencies

If you have any questions, please contact Provider Services at 1(877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 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' 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, but also key State and county-level contacts. When calling California Health & Wellness, please have the following information available:

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

California Health & Wellness Plan Information		
California Health & Wellness 1740 Creekside Oaks Drive, Suite 200 Sacramento, CA 95833 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)	(877) 658-0305 www.mhn.com	Not Applicable
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	1-866-685-8664	Not Applicable
Envolve Pharmacy Solutions www.envolvehealth.com	1-855-330-2338	1-866-399-0929
Envolve Vision Care visionbenefits.envolvehealth.com By email: EBONM@envolvehealth.com	(800) 531-2818	(877) 940-9243
Non-Emergent Transportation www.cahealthwellness.com	(877) 658-0305	Not Applicable

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

For assistance with Electronic Claims Submissions
California Health & Wellness 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

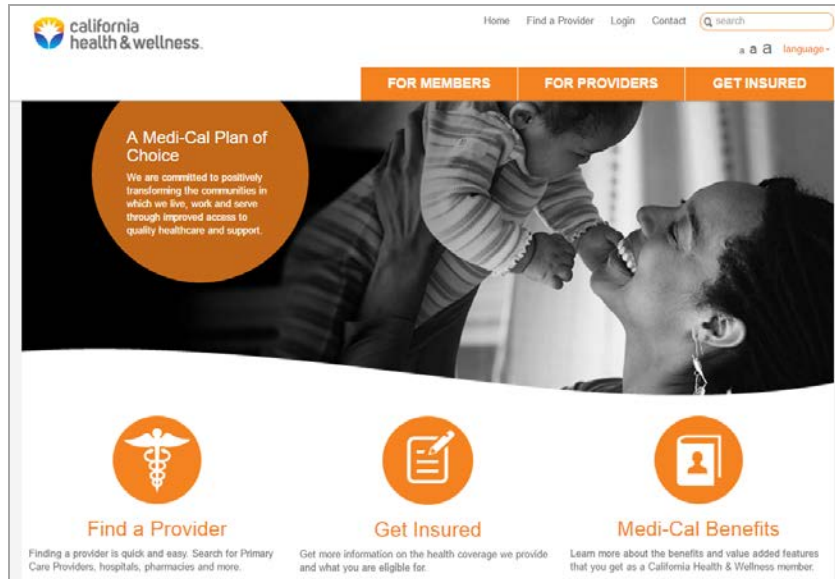
California Department of Health Care Services (DHCS)	(916) 445-4171
California Department of Managed Health Care (DMHC)	1-888-466-2219

Provider Resources on the California Health & Wellness Website

The California Health & Wellness 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' 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 News
- Clinical Guidelines
- Provider Bulletins
- Provider Newsletters
- Member Handbook
- “Find a Provider” tool to identify California Health & Wellness contracted providers



Secure Provider Portal

The California Health & Wellness 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 staff. California Health & Wellness' 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.

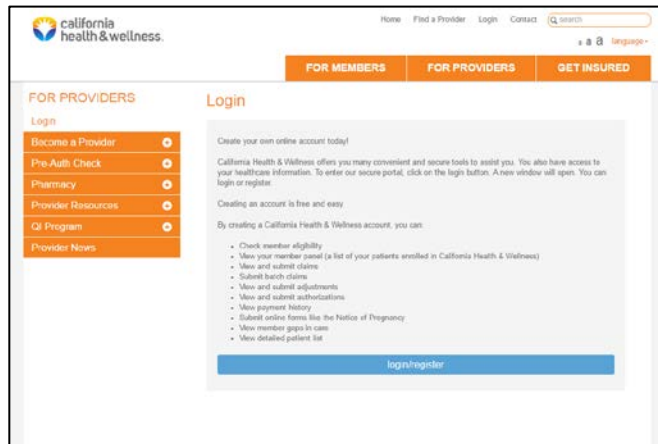
To register, go to www.cahealthwellness.com. On the home page, select the "Login" link on the top right to start the registration process. A step-by-step registration overview is provided below. Further instructions including an instructional video are available on our website and can be accessed by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

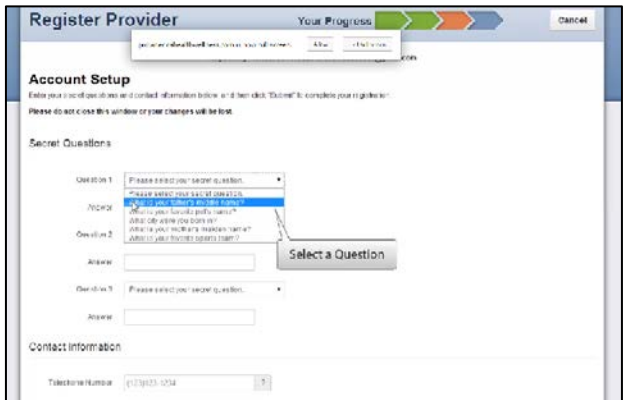
(NOTE: If you receive the following error message: “We could not find your Tax ID in our system”, please return to the “Become a Provider” page on our website to join the network. As an alternative, you can submit your first claim using an EDI vendor, or submit a claim on paper. Once your provider data 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 for approval. You should receive an email and have access to the provider website within 2 business days.



Once registered, a California Health & Wellness 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 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 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 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 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 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

Date of Service	<input type="text" value="07/10/2015"/>	Member ID or Last Name	<input type="text" value="123456789 or Smith"/>	DOB	<input type="text" value="mm/dd/yyyy"/>	<input type="button" value="Check Eligibility"/>	<input type="button" value="Print"/>
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How to Check Eligibility Using California Health & Wellness’ IVR Line

To use California Health & Wellness’ 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 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’ 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’ 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' 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' secure Provider Portal, but is not available on AEVS.

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

In some limited cases, the eligibility information on California Health & Wellness' 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 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 members receive a California Health & Wellness 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 telephone number
- Pharmacy information
- The California Health & Wellness name
- The Member Services 24-hour, seven days a week number: (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 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 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.



Pharmacy Help Desk:
 1-844-276-1398
 RXBIN: 004336
 RXPCN: MCAIDADV
 RXGROUP: RX5430

Member Name: John D Doe
Member ID: 0123456789
Effective Date:
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

IMPORTANT CONTACT INFORMATION

Members
 Pharmacy: 1-877-658-0305
 Member Services: 1-877-658-0305
 Vision: 1-877-658-0305
 24/7 NurseWise: 1-877-658-0305
 Behavioral Health: 1-877-658-0305

Providers:
 Provider Services & IVR Eligibility Inquiry:
 1-877-658-0305
 Prior Auth: www.CAHealthWellness.com or
 1-877-658-0305
 Pharmacy: 1-844-276-1398
 Vision: 1-866-921-7961

Medical Claims:
 California Health & Wellness
 Attn: Claims
 PO Box 4080
 Farmington, MO 63640-3835

If you have an emergency, call 911 or go to the nearest emergency room (ER). Emergency services by a provider not in the plan's network will be covered without prior authorization.

EDI Claims - Please submit using payer ID 68Q047
EFT/RFA please visit: For Providers page at www.CAHealthWellness.com

California Health & Wellness Address:
 1740 Creekside Oaks Drive, Suite 200
 Sacramento, CA 95833

Eligibility Categories Covered by California Health & Wellness

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 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:

- Temporary Assistance for Needy Families (TANF)
- Seniors and Persons with Disabilities (SPD)
- Medicaid Covered Expansion (MCE)
- Supplemental Security Income (SSI)
- SSI-linked Dual Eligibles (SSI Duals)
- Foster Care

California Health & Wellness' Service Area

The California Health & Wellness 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 Benefits

California Health & Wellness 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 covers, at a minimum, those core benefits and services specified in our Agreement with the California Department of Health Care Services. **California Health & Wellness 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 .

Service	Coverage	Details and Limitations
Adverse childhood experiences (ACEs) screening	Covered	<p>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.</p> <p>Contracted providers must match the correct HCPCS code based on the score and description of the screening performed.</p> <p>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.</p> <p>The medical plan is financially responsible. All providers delivering ACEs services need to submit their claims to CHWP.</p> <ul style="list-style-type: none"> • Under age 21, payment is allowed once during a 12-month period, per member screened by that provider. • Age 21 and up to 65 (adult), payment is allowed once per lifetime, per member screened by that provider. <p>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.</p>
Alcohol Misuse Screening and Behavioral Counseling	Covered	<p>Providers are required to include alcohol misuse screening and behavioral counseling services annually for Medi-Cal members ages 18 and older</p> <p>The Department of Health Care Services (DHCS) requires the use of the following validated screening tools:</p> <ul style="list-style-type: none"> • The Alcohol Use Disorder Identification Test (AUDIT)

Service	Coverage	Details and Limitations
		<ul style="list-style-type: none"> The Alcohol Use Disorder Identification Test-Consumption (AUDIT-C), or <p>A single-question screening, such as asking, "How many times in the past year have you had (for women and all adults ages 65 and older) four or (for men) five or more drinks in a day?"</p>
Alcohol and Substance Abuse Treatment Services (including drugs used for treatment and outpatient heroin detoxification services)	Not covered by the Health Plan	<p>Refer to Medi-Cal for limits by using the following link: Drug Medi-Cal Treatment Program link. Please bill the state for these services.</p> <p>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.</p>
Allergy Services (testing and desensitization)	Covered	<p>Limits applicable when office visits billed in conjunction with allergy services.</p> <p>For more information, please use the following link to the Medi Cal Manual: allergy services.</p>
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 does not require prior authorization (subject to medical necessity). Rotary wing transport does not require prior authorization.
Ambulance - Non-emergency medical transportation	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).

Service	Coverage	Details and Limitations
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.
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	<p>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.</p> <p>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”.</p>
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 .

Service	Coverage	Details and Limitations
Behavioral Health Treatment (BHT) for Autism Spectrum Disorder	Covered	<p>Members do not qualify for BHT services if they:</p> <ul style="list-style-type: none"> • Are not medically stable; or • Need 24-hour medical or nursing services; or • Have an intellectual or developmental disability (ID/DD) and need procedures done in a hospital or an intermediate care facility (ICF/ID). <p>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.</p> <p>Members can call California Health & Wellness if they have any questions or ask their Primary Care Provider for screening, diagnosis and treatment of ASD.</p> <p>Services provided in the school setting are covered by the school district</p>
Biofeedback	Not covered by the Health Plan	
Birthing Centers	Covered	<p>Limitations may apply. For more information, please use the following link to the Medi-Cal Manual: birthing centers.</p>
Blood and Blood Derivative Products	Covered	<p>Limitations may apply, please use the following link to the Medi-Cal Manual: blood products</p>
Blood Pressure Equipment (DME)	Covered	<p>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.</p>

Service	Coverage	Details and Limitations
Bone Density Testing	Covered	<p>Limitations apply: One test per year for specified diagnoses.</p> <p>Not covered if provided for screening purposes only.</p>
Breast Pumps (DME)	Covered	<p>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.</p>
California Children’s Services (CCS) Program medical services for children with certain special health problems	Covered by California Children’s Service Program	<p>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.</p>
Certified Nurse Midwife	Covered	<p>Please use the following link for more information about limitations: Certified Nurse Midwife limitations</p>
Chemotherapy	Covered	<p>For members under age 21, please refer to CCS guidelines using the following link: CCS Chemotherapy.</p> <p>Also contact the DHCS Children’s Medical Services for more information – use the following link for more information: CCS Contacts.</p> <p>CCIPA: Chemotherapy (including adjunctive therapy) is covered by CH&W.</p>

Chiropractic Services	Covered	<p>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.</p> <p>The following information is required for appropriate billing of chiropractic services.</p> <ul style="list-style-type: none"> • 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 border="1" data-bbox="990 1150 1328 1598"> <thead> <tr> <th>CPT code</th> <th>Type of visit</th> <th>Maximum allowance</th> </tr> </thead> <tbody> <tr> <td>98940</td> <td>Chiropractic manipulative treatment (CMT); spinal, one to two regions</td> <td>\$16.72</td> </tr> <tr> <td>98941</td> <td>Chiropractic manipulative treatment (CMT); spinal, three to four regions</td> <td>\$16.72</td> </tr> <tr> <td>98942</td> <td>Chiropractic manipulative treatment (CMT); spinal, five regions</td> <td>\$16.72</td> </tr> </tbody> </table> <table border="1" data-bbox="990 1707 1328 1881"> <thead> <tr> <th>ICD-10-CM CODE</th> <th>DESCRIPTION</th> </tr> </thead> <tbody> <tr> <td>M50.11– M50.13</td> <td>Cervical disc disorder with radiculopathy</td> </tr> <tr> <td>M51.14– M51.17</td> <td>Intervertebral disc disorders with radiculopathy</td> </tr> </tbody> </table>	CPT code	Type of visit	Maximum allowance	98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	\$16.72	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
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Child Health and Disability Prevention (CHDP) Services	Covered	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 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 Provider Network Specialist for more specific information.
Community Based Adult Services (CBAS)	Covered	Limitations apply. CBAS is described further in this Manual, 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 .
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: Covered through 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

		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 3 times in a 12-month period. Attending physicians or nurses must provide the service.
Gender Reassignment Surgery	Covered	Covered only for members age 18 & over. Procedures that are not medically necessary are not covered.
Health Education	Covered	Coverage limited for pregnancy services only. Please see use this 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 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, use the following link to the Vaccine/Immunization guidelines: https://www.cahealthwellness.com/providers/pharmacy/Vaccinations.html .
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. (Not available through the pharmacy benefit for children under age 19 years)
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	<p>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 Health Program facility: Find a Provider.</p> <p>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.</p> <p>For IHS claims for specialty services vendors, use the forms indicated below:</p> <ul style="list-style-type: none"> • American Specialty Health, Inc. (acupuncture claims): CMS-1500 • Envolve Vision (vision services): CMS-1500 • MHN (behavioral health): UB-04

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	<p>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.</p> <p>Self-administered injectables: covered through the pharmacy benefit</p> <p>Provider-administered injectables: covered through the medical benefit.</p> <ul style="list-style-type: none"> • CCIPA: CCIPA covers all provider-administered medications except for chemotherapy (including adjunctive therapy) and transplant immunosuppression. <p>The CH&W website Pharmacy page contains the injectable medication HCPC/DOFR crosswalk to determine provider-administered “therapeutic” vs. self-administered injectables.</p>
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 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 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)	Not covered by the Health Plan. Please bill the state Medi-Cal program for these services	Upon acceptance by state for LTC, member is dis-enrolled from California Health & Wellness Plan. Long-term care (LTC) is care in a facility for longer than the month of admission plus one month. These health care facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities Refer to Medi-Cal for limits here: Long-Term Care . Please note: Hospice services are not considered LTC.
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) – other than ambulance	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	Benefit managed by Envolve Pharmacy Solutions www.envolvehealth.com
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 .
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 Provider Network Specialist for more information. For a list of covered smoking cessation drugs, refer to the Pharmacy Programs Chapter in this Manual at the following link: (Smoking Cessation) For a complete listing of covered medications and associated restrictions, refer to the Preferred Drug List (PDL) at the following link: (PDL)
Transplant Services – Kidney	Covered for members over age 21. Covered by CCS (not covered	For members over age 21, requires prior authorization.

	by the health plan) for members under age 21	For members under age 21, refer to CCS guidelines at the following link: Transplants .
Transplant Services – Cornea	Covered for members over age 21. Covered by CCS (not covered by the health plan) for members under age 21	For members over age 21, requires prior authorization by Envolve Vision Care visionbenefits.envolvehealth.com For members under age 21, refer to CCS guidelines at the following link: Transplants .
Transplant Services – Other Major Organs	Not covered by the health plan	Upon acceptance by approved transplant program member is dis-enrolled from California Health & Wellness. For members under age 21, refer to CCS guidelines at the following link: Transplants .
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 caregiver
- PEARLS for teenagers ages 12–19, to be completed by a caregivers
- 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	Not given more than once during a 12-month period, per provider, per member
18 or 19	ACEs or PEARLS	Not given more than once during a 12-month period, per provider, per member
20-64	ACEs screening portion of the PEARLS tool (Part 1) can also be used.	<ul style="list-style-type: none"> • Not given more than once during a 12-month period, per provider, per member under age 21. • Not given more than once per lifetime, per provider, per member ages 21 and older.

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/
- www.acesaware.org/wp-content/uploads/2019/12/ACE-Clinical-Workflows-Algorithms-and-ACE-Associated-Health-Conditions.pdf
- 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.

Aunt Bertha

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.auntbertha.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 two-hour 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

California Health & Wellness arranges for the non-emergent transportation of members for medically necessary services if requested by the member or someone on behalf of the member. **To arrange for non-emergent medical transportation for a California Health & Wellness member, the provider should call our Member 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 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 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 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 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 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' network is unable to provide medically necessary services required under the contract, California Health & Wellness 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 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 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 network is unable to provide the necessary tertiary care services required, California Health & Wellness facilitates timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted. California Health & Wellness coordinates authorization and payment issues in these circumstances.

CHAPTER 5: PHARMACY PROGRAM

California Health & Wellness is committed to providing appropriate, high quality, and cost effective drug therapy to all of its members. California Health & Wellness works with providers and pharmacists to furnish coverage of medications that are used to treat a variety of conditions and diseases. California Health & Wellness covers prescription medications and certain over-the-counter (OTC) medications when prescribed by a licensed provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities.

Preferred Drug List (PDL)

What is the PDL?

The California Health & Wellness Preferred Drug List (PDL) is the list of covered drugs. The PDL applies to drugs that members can receive at retail pharmacies. The purpose of the PDL is to provide member access to quality, cost-effective medications on a timely basis. The California Health & Wellness PDL is continually evaluated by our Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications, and so that the PDL reflects changes in the drugs that are available on the market. The Committee is composed of the California Health & Wellness Medical Director, Pharmacy Director, and several California physicians, pharmacists, and other healthcare professionals. California Health & Wellness communicates to providers any changes via PDL updates, newsletters, California Health & Wellness website and provider updates.

How to Access the PDL

Providers can access the most current PDL by clicking on the following link ([PDL](#)) or by visiting the California Health & Wellness website <http://www.cahealthwellness.com>. From the home page, click on the “For Providers” tab and select “Pharmacy” from the drop down menu. The PDL is available via the “[Preferred Drug List \(PDL\)](#)” link in the middle of the page (*please refer to the screenshot below*).

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Pre-Auth Check

Pharmacy

Enteral Nutrition

Epocrates

Vaccinations

Provider Resources

QI Program

Provider News

Provider Report Newsletter

Pharmacy

Pharmacy Program at California Health & Wellness is to provide access to pharmacy services to our members, and to ensure that these services are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of pharmacy care.

Preferred Drug List

California Health & Wellness has created a Preferred Drug List (PDL). The PDL is continually evaluated by a committee of practicing physicians and pharmacists to ensure appropriate and cost-effective use of medications without compromising the quality of care. Click on the link below to see the full list.

[Epocrates](#)[Preferred Drug List \(PDL\)](#)[Provider Quick Reference Guide](#)[Pharmacy PDL Change Request Form](#)

Medication Prior Authorization Requests

Some medications require prior authorization from California Health & Wellness in order for reimbursement to be issued to the provider. Medications requiring prior authorization include:

- Medications not listed on the Preferred Drug List (PDL)
- Medications listed on the PDL with restrictions or limitations, such as:
 - Step Therapy
 - Quantity Limit
 - Age Limit

Use the form below when submitting a prior authorization request for medications:

[Prescription Drug Prior Authorization Request Form \(No. 61-211\)](#)

Please note the contact information differs based on the type of prior authorization request being made:

Providers can also access the PDL via mobile device or online by using Epocrates (<http://www.epocrates.com>).

Dispensing Limits

California Health & Wellness uses dispensing limits to help manage the utilization of prescription drugs by its members. Drugs may be dispensed up to a maximum of thirty (30) days' supply for each new prescription or refill (90-day supply for smoking cessation drugs, a 12-month supply for the same self-administered hormonal contraceptives may be dispensed twice in one year). For all drugs, 80 percent of the days' supply must have elapsed before the prescription can be refilled.

Generic Drugs

To promote cost-effective use of prescription drugs, California Health & Wellness covers generic drugs in lieu of brand name drugs when a generic version of the drug is available. When a generic version of a drug is available, the brand name drug is not covered unless authorized by California Health & Wellness. Generic drugs have the same active ingredient and work the same as brand name drugs. If the member or his/her provider believes that a brand name drug is medically necessary, the provider can request the brand drug using the prior authorization process. California Health & Wellness covers the brand-name drug if there is a medical reason that the member needs the particular brand-name drug based upon clinical guidelines. If

California Health & Wellness does not grant authorization, it notifies the member and his/her provider and furnishes information regarding the appeal process.

The generic drug provision is waived for the following products due to their narrow therapeutic index (NTI) as recognized by current medical and pharmaceutical literature: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Procainamide, Theophylline, Thyroid, Valproic Acid, and Warfarin.

Over-the-Counter Medications

California Health & Wellness covers a variety of over-the-counter (OTC) medications. These medications can be found throughout the California Health & Wellness PDL. California Health & Wellness covers OTC products listed in the PDL if the member has a prescription from a licensed provider that meets all the legal requirements for a prescription.

Smoking Cessation Drugs

California Health & Wellness covers medications to help members quit smoking. These drugs include:

- Generic OTC nicotine products (gum, lozenges, and patches)
- Nicotine Inhaler (Nicotrol[®] Inhaler), Nicotine Nasal Spray (Nicotrol[®] NS), Bupropion SR (Zyban[®])
- Varenicline Tartrate (Chantix[®])

Enteral Nutrition Products

California Health & Wellness covers enteral nutrition products under the following conditions:

- Home Infusion: Submit Pump Enteral Nutrition Prior Authorizations to California Health & Wellness Pharmacy Department at 877-259-6961. Billing must be through California Health & Wellness Medical Billing.
- Bolus/Gravity: Submit Bolus (no pump) Enteral Nutrition Prior Authorizations to Envolve Pharmacy Solutions at 866-399-0929. Billing must be handled through a network pharmacy using pharmacy claims.
- If the member is under 21 years old, CCS eligibility is verified.

Continuation of Care for Transitioning and New Members

- Either the prescriber or pharmacy may request continuity of care coverage by faxing a prior authorization request, or by calling Envolve Pharmacy Solutions at **1-855-330-2338** with drug history information.
- New and transitioned members who were taking a non-PDL medication immediately prior to enrollment in California Health & Wellness are eligible for continued coverage of a single source medication. (A single source medication is one that has no generic version available).

- Continuation of care for medications requiring prior authorization will be initially covered for 90 days or the length of the previously approved authorization, whichever is longer, and then reviewed per re-authorization criteria.
- Excluded and carved-out medications/products are not eligible for continuation of care.

“Carve Out” and Other Non-Covered Drugs

Not all drugs are included on the California Health & Wellness Preferred Drug List (PDL). Other programs such as the Medi-Cal Fee-for-Service Program and California Children’s Services (CCS) also cover some “carve out” drugs. Certain drugs are also excluded from the PDL.

“Carve Out” Drugs Covered by the Medi-Cal Fee-For-Service Program

Certain drugs are not covered by California Health & Wellness, but instead are covered by the Medi-Cal Fee-For-Service program, which is administered by the California Department of Health Care Services (DHCS). All authorization requests and claims for the specific drugs listed in the Medi-Cal Provider Manual (http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpimperial_z01.doc) are submitted directly to Medi-Cal Fee-For-Service. 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. All authorization requests and claims must be submitted directly to the CCS program.

Exclusions

The following drug categories are not part of the California Health & Wellness PDL and are not covered by the 72-hour emergency supply policy:

- Drugs that are considered experimental
- Drug Efficacy Study and Implementation (DESI) drugs
- Drugs prescribed for infertility
- Drugs prescribed for erectile dysfunction
- Drugs prescribed for cosmetic purposes or hair growth
- Over-the-counter (OTC) cough and cold preparations
- Over-the-counter (OTC) adult acetaminophen products
- Common household remedies and the following non-legend drug preparations:
 - Benzoic and Salicylic Acid Ointment (pre-compounded)
 - Salicylic Acid Cream, Ointment or Liquid
 - Sodium Chloride Tablets, 1 gram or 2.5 grams
 - Zinc Oxide Paste

- Medical foods (e.g., banana flakes), probiotics not on the List of Enteral Nutrition Products
- Herbal product combinations (e.g., hydrocortisone with aloe vera, etc.)
- Food supplements, combinations of vitamins/minerals and multivitamin supplements, unless otherwise defined and described within the Preferred Drug List.

Drug Efficacy Study and Implementation (DESI) Drugs

Drug Efficacy Study and Implementation (DESI) products and known related drug products are defined as less than effective by the Food and Drug Administration because: (1) there is a lack of substantial evidence of effectiveness for all labeling indications; and (2) because a compelling justification of medical need has not been established. DESI products are not covered by California Health & Wellness.

Requesting Prior Authorization (PA) for Medications

Some medications listed on the California Health & Wellness PDL may require prior authorization. A licensed clinical pharmacist reviews authorization requests using the criteria established by the California Health & Wellness Pharmacy and Therapeutic Committee (P&T). These criteria are consistent with review of current pharmaceutical and medical literature, peer reviewed journals and professional standards of practice. Prior authorization guidelines generally require that certain conditions be met before coverage of drug therapy is authorized.

How to Request a Medication Prior Authorization

California Health & Wellness works with **Envolve Pharmacy Solutions** to process all pharmacy claims for prescribed drugs. Envolve Pharmacy Solutions is responsible for administering the medication prior authorizations process on behalf of California Health & Wellness 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 website, and fax the request to Envolve Pharmacy Solutions at **1-866-399-0929**.
 - b. *Online:* A prior authorization form can be completed and submitted electronically using CoverMyMeds.[®]

CoverMyMeds is California Health & Wellness' preferred way to receive prior authorization requests. Visit go.covermymeds.com/envolve to begin using this free service.

There are three options for submitting a prior authorization form:

1. Submit the prior authorization electronically through CoverMyMeds at go.covermymeds.com/envolve.
 2. Complete and submit Envolve's online form at <https://paform.envolverx.com>.
 3. Print the appropriate form found on the California Health & Wellness provider portal under *Pre-Auth Check > Medi-Cal Pre-Auth > Prescription Drug Prior Authorization or Step Therapy Exception Request Form (No. 61-211)*. Once you have printed the form and completed all appropriate fields, fax the completed form to the number listed on the form.
2. If approved, Envolve Pharmacy Solutions notifies the prescribing provider by fax.
3. 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. The member and provider are also provided information regarding the appeal process. If a prior authorization is denied, the provider can call Envolve Pharmacy Solutions at **(877) 277-0413** to discuss the denial with the reviewing Pharmacist (known as "**Peer to Peer Review**"). If the provider is not satisfied with the Peer-to-Peer outcome, the provider can submit an appeal to the plan either by mail, phone or fax.

Medications Requiring a Prior Authorization

Some medications require prior authorization from California Health & Wellness. These include the following:

- Medications not listed on the Preferred Drug List (PDL)
- Medications that are listed on the Preferred Drug List and specifically require prior authorization
- Medications that are on the Preferred Drug List with restrictions or limitations and the member has not satisfied the required restrictions or limitations, such as those that require the following:
 - Prior Authorization
 - Step Therapy
 - Quantity Limit
 - Age Limit
 - Gender Limit

California Health & Wellness will cover the medication if it is determined that:

1. There is a medical reason the member needs the specific medication
2. Depending on the medication, other medications on the PDL have not worked

Step Therapy

In order to receive some medications listed on the PDL, California Health & Wellness may first require the use of other specific medications. Such medications are referred to as "step therapy medications". If California Health & Wellness has a record that the member tried the required

medication first, California Health & Wellness then covers the step therapy medications automatically. If California Health & Wellness' records indicate that the member has not yet tried the required medication, California Health & Wellness may require the member's provider to furnish additional information. If authorization is not granted, California Health & Wellness notifies the member and the member's provider and furnishes information regarding the appeal process.

Quantity Limits

To help manage appropriate medication use, California Health & Wellness may limit how much of a certain medication a member can receive at one time. The member's provider may request prior authorization if the provider believes the member has a medical reason for receiving a greater amount. If California Health & Wellness does not grant an authorization request, it notifies the member and the member's provider and furnishes information regarding the appeal process.

Age Limits

Some medications on the California Health & Wellness PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

Gender Limits

Some medications on the California Health & Wellness PDL may be limited to one gender. These limits are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Gender limits align with current FDA alerts for the appropriate use of pharmaceuticals.

Medical Necessity Requests for Drugs Not on the PDL

If the member requires a medication that does not appear on the PDL, the member's provider can make a medical necessity request for the medication using the prior authorization process (see section below [Prior Authorization Determinations](#)). In general, California Health & Wellness' PDL medications are appropriate for use in treating the vast majority of medical conditions. For a medical necessity request, California Health & Wellness requires documentation of the following:

- Failure of at least two PDL agents within the same therapeutic class (provided two agents exist in the therapeutic category with comparable labeled indications) for the same diagnosis (e.g. migraine, neuropathic pain, etc.)
- Intolerance or contraindication to at least two PDL agents within the same therapeutic class (provided two agents exist in the therapeutic category with comparable labeled indications)
- A clinical history or presentation where the patient is not a candidate for any of the PDL agents for the indication

72-Hour Emergency Supply Policy

State and Federal law require that a pharmacy dispense a 72-hour (3-day) emergency supply of medication to any member awaiting prior authorization determination. An emergency is when lack of medical help could result in danger to a member's health or, in the case of a pregnant member, the health of her unborn child. All participating pharmacies are authorized to provide a 72-hour emergency supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour emergency supply of medication, whether or not the PA request is ultimately approved or denied. The pharmacy must **call Envolve Pharmacy Solutions at 1-855-330-2338** for a prescription override to submit the 72-hour medication emergency supply for payment. Excluded and carved-out medications/products are not eligible for a 72 hour emergency supply.

Vacation Overrides

- Vacation overrides may be approved for up to a 30-day supply
- One override allowed per drug per 12 months
- Either the prescriber or pharmacy may request a vacation override by faxing a prior authorization request, or calling Envolve Pharmacy Solutions at **1-855-330-2338** with drug history information.

Lost/Stolen Medication Overrides

- Lost/stolen medication overrides may be approved for up to a 30-day supply
- A police report is required for stolen medications. Controlled substances may or may not be approved for lost/stolen overrides.
- Either the prescriber or pharmacy may request a lost/stolen medication override by faxing a prior authorization request, or calling Envolve Pharmacy Solutions at **1-855-330-2338** with drug history information.

Prior Authorization Determinations

The provider is notified of a decision within 24 hours or 1 business day (not to exceed 72 hours) of the receipt of the prior authorization request. If the clinical information provided does not meet the coverage criteria for the requested medication, California Health & Wellness notifies the member as well as the prescriber regarding the reason for denial, listing any alternatives if appropriate, and provide information regarding the appeal process.

Filing an Appeal of a Medication Adverse Determination

A provider or member can mail, fax or call California Health & Wellness to file an appeal within 60 days of the denial to:

California Health & Wellness Plan Appeal Department

1740 Creekside Oaks Drive, Suite 200

Sacramento, CA 95833

Phone (877) 658-0305

(For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number)
Fax 1-855-460-1009

If a provider initiates an appeal on behalf of the member, the member is required to submit a signed Authorized Representative Form which allows the provider to act on behalf of the member and is located at www.CAHealthWellness.com and can be obtained by using the following link: [Authorized Representative Form](#). For more information on the specific steps and timeframes regarding the member appeal process, please see Chapter 17: Grievance and Appeals (or use the following link: [grievance and appeals](#)).

Provision of Specialty Pharmacy Medications

AcariaHealth is the provider of self-administered specialty medications for California Health & Wellness. 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 the completed form by fax to Envolve Pharmacy Solutions at **(866) 399-0929**.
- 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.

Physician-Administered Medication Requests

California Health & Wellness 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

Please route Prior Authorization requests accordingly, using the [use the Prescription Drug Prior Authorization Request Form \(No. 61-211\)](#).

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?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving inpatient hospice services?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Are plastic or oral surgeon services being rendered in the office?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for transgender surgery or other procedures?	<input type="radio"/>	<input checked="" type="radio"/>
Does the member have a CCS diagnosis?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

P **J9355** - TRASTUZUMAB INJECTION
 Pharmacy Pre-authorization is required for all providers. Please submit all drug requests by using the Prescription Drug Authorization Form below.

To submit a prior authorization [Login Here](#).

To submit a medication prior authorization, use the [Prescription Drug Prior Authorization Request Form \(No. 61-211\)](#).

- 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 at **(877) 259-6961**
 - If approved, the prescriber is notified by fax

- If needed, California Health & Wellness 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

Food and Drug Administration (FDA) Recalls

When California Health & Wellness is notified of a Food and Drug Administration (FDA) drug recall, California Health & Wellness promptly notifies affected members and their prescribing providers. This applies to the following types of FDA recalls: Class I drug recalls, Class II or Class III recalls deemed to have serious safety concerns, or market withdrawal of drugs for safety reasons. The FDA categorizes all recalls into one of three classes according to the level of hazard involved:

- Class I Recall: Class I Recalls are for dangerous or defective products that predictably could cause serious health problems or death. Examples of products that could fall into this category are: a label mix-up on a life saving drug, or drugs found to be subpotent that are used to treat life threatening conditions.
- Class II Recall: Class II Recalls are for products that might cause a temporary health problem, or pose only a slight threat of a serious nature. One example is a drug that is under-strength but that is not used to treat life-threatening situations.
- Class III Recall: Class III Recalls are for products that are unlikely to cause any adverse health reaction, but that violate FDA labeling or manufacturing regulations. Examples might be a container defect (plastic material delaminating or a lid that does not seal); off-taste, color, or leaks in a bottled drink, and lack of English labeling in a retail food.

Drug Utilization Review (DUR) Program

California Health & Wellness utilizes prospective and retrospective DUR programs using standards, criteria, protocols, and procedures approved by the California Health & Wellness 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 and entities delegated to fill prescriptions for outpatient drugs (“applicable entities”) must:

- Operate a drug utilization review (DUR) program¹
- 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 the topics listed below.

- Safety edits, including early, duplicate and quantity limits

Describe the opioid-related prospective safety edits, as well as the automated process for retrospective claims review that California Health & Wellness or the applicable entity has in place to address: duplicate fill, early fill and quantity limits. California Health & Wellness and applicable entities must not allow refills earlier than 75% of the time when the previous fill should be exhausted; duplication of the same service on the same date of fill; and the provision of acute medications in excess of a 30-day supply, or for chronic medications, a 90-day supply without prior authorization approval.

- Maximum daily morphine milligram equivalents (MME) safety edits
 - 1 Describe the prospective safety edits for the maximum MME/daily that can be prescribed to a member enrolled for treatment of chronic pain, not to exceed 500 MME/daily without prior authorization. This safety edit must include a MME/daily threshold amount to assist in identifying members at potentially high-clinical risk who may benefit from closer monitoring and care coordination.
 - 2 Describe the automated process for claims review (retrospective review) that indicates when a member is prescribed the morphine equivalent for such treatment in excess of the maximum MME/daily dose limitation.
- Concurrent utilization alerts

Describe the automated process for claims review (retrospective) that monitors when a member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. (This does not preclude the establishment of a prospective safety-edit

system to provide additional information to patients and providers at the point-of-sale about concurrent utilization.) Managed care plans (MCPs) and applicable entities that are not capitated for antipsychotic drugs will be provided claims data, including for antipsychotic medications. California Health & Wellness and applicable entities are expected to perform, retrospectively, regular care management activities, including a review of concurrent use of opioid and antipsychotic medications, and take action accordingly on issues of concern to them.

- Permitted exclusions

The above described safety edits and claims review requirements do not apply to members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; members who are receiving opioid agonist medications for treatment of substance use disorder; or other individuals the state elects to treat as exempted from such requirements.

Monitoring of antipsychotic medications used by children

MCPs (and applicable entities) that are capitated for all psychiatric drugs, including antipsychotic medications, must describe the program they use to monitor and manage utilization of antipsychotic medications in children and foster children. MCPs and applicable entities must also describe the actions they will take based on DUR program monitoring. The use of antipsychotic medications outside of U.S. Food and Drug Administration-approved indications or doses needs prior authorization approval. Also, ongoing use of two or more antipsychotic medications must be medically justified and closely monitored.

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.

¹The 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 members can receive as Medi-Cal beneficiaries, although these services are not covered by California Health & Wellness specifically. They may be covered by the Medi-Cal Fee-for-Service Program, 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 member who needs services that are covered by the Medi-Cal Fee-for-Service program and not by California Health & Wellness, 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, 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 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. 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 and should be billed to the State. We will assist with coordination of services as needed. California Health & Wellness members can receive these services without having to disenroll from California Health & Wellness.
- **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. 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 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 does not pay for services that are covered by CCS.

California Health & Wellness 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 covers some medical services that support dental procedures. However, if a California Health & Wellness member needs dental care, the member's PCP should refer him/her to a Denti-Cal dental provider. California Health & Wellness 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 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.
- **Organ Transplantation** - Except for cornea and kidney transplants, California Health & Wellness members will disenroll from California Health & Wellness and return to the Medi-Cal Fee-for-Service program to receive an organ transplant. Solid Organ transplants are not a benefit of California Health & Wellness (subject to state regulation changes).
- **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' service area.

Regional Center	Website	California Health & Wellness 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.cvr.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.
- **Skilled Nursing Facility or Intermediate Care Facility** - California Health & Wellness covers medically necessary admissions to a skilled nursing facility or intermediate care facility. Maximum coverage is limited to the month of admission and the following month. After that, members must disenroll from California Health & Wellness and return to the Medi-Cal Fee-for-Service program to receive long-term care services.

Please note that a member can remain enrolled in California Health & Wellness if the member has elected hospice services and is admitted to a skilled nursing facility.

- **Specialty Mental Health** - California Health & Wellness 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, members can receive these services with or without a referral from their doctor, and without having to disenroll from California Health & Wellness. Members can receive these services with or without a referral from their doctor, and without having to disenroll from California Health & Wellness.

Please instruct California Health & Wellness members who are in need of specialty mental health services to contact their PCP or California Health & Wellness 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 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 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’ 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’ 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 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 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’ 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 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' UMP provides the following service reviews:

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

California Health & Wellness 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 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 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 should notify California Health & Wellness 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 providers are contractually prohibited from holding any member financially liable for any service administratively denied by California Health & Wellness 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

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 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 as of January 2019

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	
Ambulance - non-emergency air transportation	
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
<p>Durable medical equipment (DME) - including but not limited to:</p> <ul style="list-style-type: none"> • 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, repairs and accessories • Prosthetics • Ventilators 	<p>All DME for pediatric members requires prior authorization</p> <p>Certain procedure codes; call or go to CHW website to determine if authorization is required</p>
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	
Intensive cardiac rehabilitation (ICR) services – outpatient	<p>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:</p> <ul style="list-style-type: none"> • CMS-approved program the member is participating in • Qualifying diagnosis • Treatment plan • Duration of services
Joint surgeries	
<p>Laboratory services:</p> <ul style="list-style-type: none"> • Genetic/molecular diagnostic testing • Quantitative drug screening 	
Lung volume reduction	
Maze procedures	
Mental health	<p>Services such as psychological testing and neuropsychological 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.</p>
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 CHW website to determine if authorization is required
Outpatient therapies: physical, occupational and speech	Requires prior authorization after 12 combined visits.
Pain management services	
Pharmacy services	See PDL on CHW website for list of covered drugs and Limitation/Restrictions – notification within 1 business day of request receipt. The plan will cover the pharmacy to dispense a 72-hour emergency supply of an outpatient drug while awaiting a prior-authorization decision.
Radiology imaging-CT, MRA, MRI, PET	Go to www.radmd.com
Reconstructive and cosmetic surgery, services and supplies, including, but not limited to: <ul style="list-style-type: none"> • 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 CH&W Provider Website “Pharmacy” page for Specialty Pharmacy PA Information and “Pre-Auth

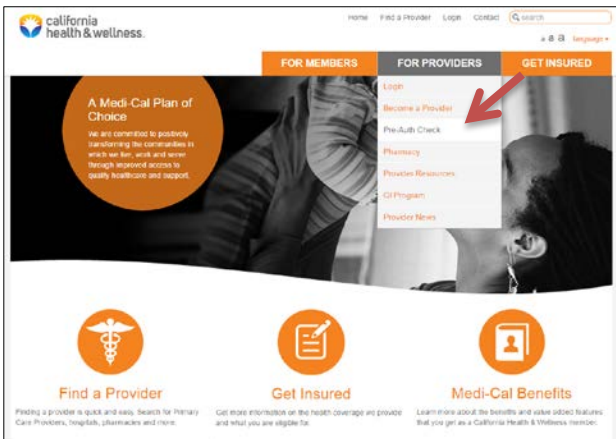
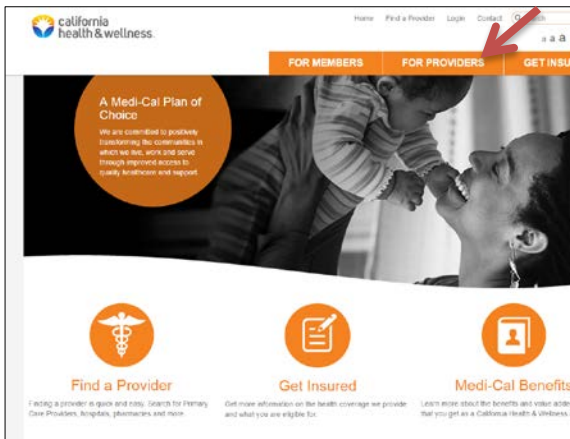
	Check” page for checking PA status of provider administered drugs.
Spinal surgery, includes, but not limited to, laminotomy, discectomy, vertebroplasty, nucleoplasty, and X-stop	
Transplant services including evaluation	
Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP	
Ventriculectomy, cardiomyoplasty	
Vestibuloplasty	

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

How to Check Online Whether Prior Authorization is Needed

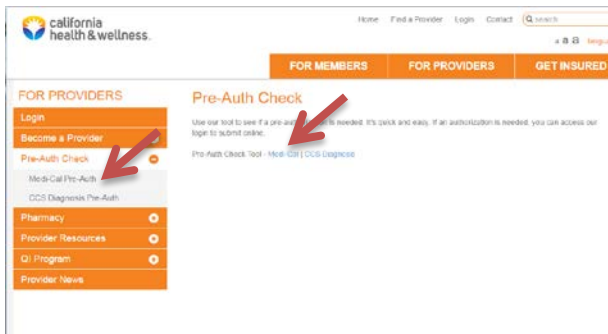
Providers can check if a prior authorization is required for specific codes by using the California Health & Wellness website.

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.



FOR PROVIDERS

Medi-Cal Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. A pre-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 pre-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, MRI, MRU, PET, and CT Scans need to be verified by SCS.
 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 their Authorization Request Form, Outpatient Form for all services except 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
Is the member being admitted to an inpatient facility?	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>
Is the member receiving inpatient hospice services?	<input type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>
Are plastic or oral surgeon services being rendered in the office?	<input type="radio"/>
Are services for transgender surgery or other procedures?	<input type="radio"/>
Does the member have a CCS diagnosis?	<input type="radio"/>

Enter the code of the service you would like to check:

Code:

To submit a prior authorization [Login Here](#).

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’ 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’ secure Provider Portal (see screenshot below).

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Home Find a Provider Login Contact Search

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 Health Forward 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 Optician.
 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 HSA.
 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

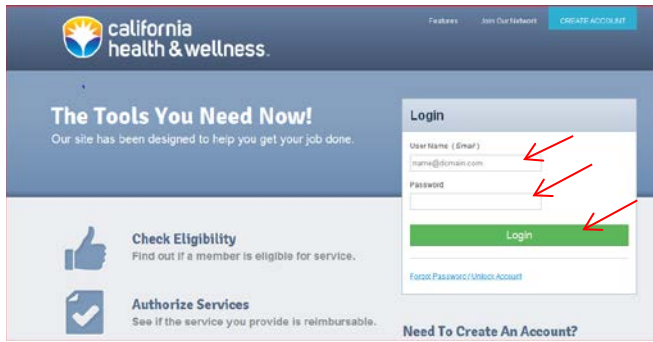
Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving inpatient hospice services?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Are plastic or oral surgeon services being rendered in the office?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for transgender surgery or other procedures?	<input type="radio"/>	<input checked="" type="radio"/>
Does the member have a CCS diagnosis?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

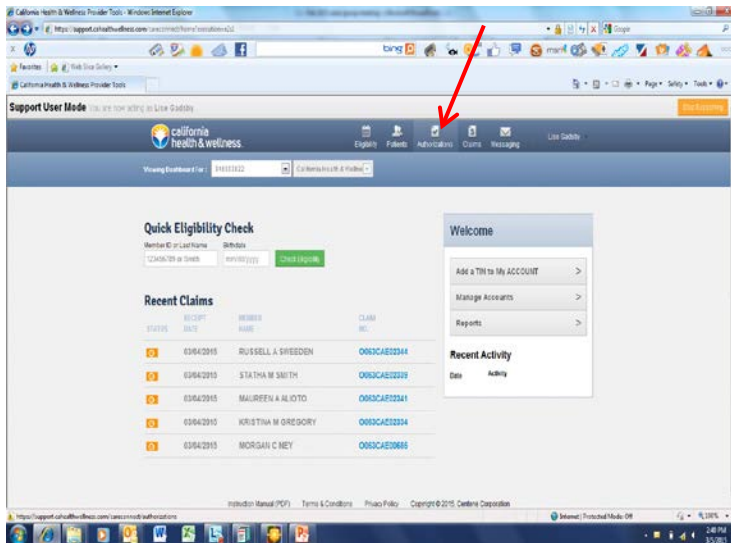
Code:

To submit a prior authorization [Login Here](#).

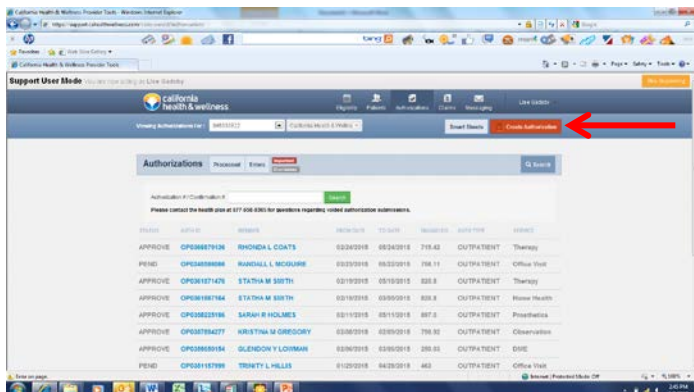
Step 2: Enter your user name and password and click on “Login.”



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:

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.

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Contrast On Off a a a 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

Provider Report Newsletter

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 Envolve Vision Care
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](#)
For Enteral Nutrition, please visit our [Enteral Nutrition](#) page.

CCIPA PROVIDERS PLEASE NOTE:

- CCIPA is responsible for all Prior Authorization of provider-administered medications except for chemotherapy (including adjunctive therapy) and transplant immunosuppression.
- California Health & Wellness is responsible for prior authorization of ALL provider-administered medications for chemotherapy (including adjunctive therapy) and transplant immunosuppression.
- Please see the injectable medication HCPS/DOFR Crosswalk to determine provider-administered "therapeutic" vs. self-administered injectables.

Please route Prior Authorization requests accordingly, using the [Prescription Drug Prior Authorization Request Form \(No. 61-211\)](#).

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?

How to submit Physician-Administered Drug Prior Authorization Requests

California Health & Wellness 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 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 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 \(No. 61-211\)](#)
- Form can be found at www.CAHealthWellness.com/For Provider/ Pharmacy
- Submit a completed form by fax to California Health & Wellness Pharmacy Department at (877) 259-6961

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

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

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is pertinent 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

First Name: _____ Last Name: _____ MI: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Male Female Circle unit of measure: _____ Height (in/ft): _____ Weight (lb/kg): _____ Allergies: _____
Patient's Authorized Representative (if applicable): _____ Authorized Representative Phone Number: _____

Insurance Information

Primary Insurance Name: _____ Patient ID Number: _____
Secondary Insurance Name: _____ Patient ID Number: _____

Prescriber Information

First Name: _____ Last Name: _____ Specialty: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Requestor (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

Medication Name: _____
 New Therapy Renewal
Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____
How did the patient receive the medication?
 Paid under Insurance Name: _____ Prior Auth Number (if known): _____
 Other (explain): _____
Dose/Strength: _____ Frequency: _____ Length of Therapy/Refills: _____ Quantity: _____
Administration: Oral/SL Topical Injection IV Other: _____
Administration 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: _____ DOB: _____

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: _____

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- If approved, the prescriber is notified by fax
 - a) If needed, California Health & Wellness 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 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 requires providers to submit clinical documentation for all services that need prior authorization. California Health & Wellness 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 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 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 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 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 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.

Skilled Nursing Facility Admission and Review Criteria

Prior authorization is required for admission to sub-acute care facility and will be based on medical necessity for a skilled need. Long term care is not a covered benefit. Member's requiring long term care will require disenrollment to the Medi-Cal FFS program. (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 SNF:

- 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 SNF:

- Skilled Nursing at least daily and Skilled Therapy 1-2 hours per day at least 5 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 2 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.

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 Notice of Action (NOA), which may be sent to:

California Health & Wellness
Appeals Department
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833

(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 has an extensive prior authorization and utilization program. California Health & Wellness 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 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 for referrals to out of network providers. To better coordinate a member's healthcare, California Health & Wellness 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 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' Medical Management department to assist in the coordination of second opinions.

Assistant Surgeon

California Health & Wellness 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 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 network providers.

Emergency Care Services

Members may access emergency services at any time without prior authorization or prior contact with California Health & Wellness. If members are unsure as to the urgency or emergency of the situation, they can contact their PCP and/or California Health & Wellness 24-hour Nurse Triage Line for assistance; however, this is not a requirement to access emergency services. California Health & Wellness 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 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 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. California Health & Wellness covers emergency services irrespective of whether the provider is part of the California Health & Wellness provider network. California Health & Wellness 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 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 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 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 within one business day of admission with complete information regarding the delivery status and condition of the newborn.

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 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 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 *
 Member ID/Medi-Cal ID * Last Name, First (MMDDYYYY)

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	End Date	Quantity per Month	Diagnosis Code *
<input type="text"/> (MMDDYYYY)	<input type="text"/> (MMDDYYYY)	<input type="text"/>	<input type="text"/> (ICD-10)
<input type="text"/> Start Date	<input type="text"/> End Date	<input type="text"/> Quantity per Month	<input type="text"/> Diagnosis Code *
<input type="text"/> (MMDDYYYY)	<input type="text"/> (MMDDYYYY)	<input type="text"/>	<input type="text"/> (ICD-10)
<input type="text"/> Start Date	<input type="text"/> End Date	<input type="text"/> Quantity per Month	<input type="text"/> Diagnosis Code *
<input type="text"/> (MMDDYYYY)	<input type="text"/> (MMDDYYYY)	<input type="text"/>	<input type="text"/> (ICD-10)
<input type="text"/> Start Date	<input type="text"/> End Date	<input type="text"/> Quantity per Month	<input type="text"/> Diagnosis Code *
<input type="text"/> (MMDDYYYY)	<input type="text"/> (MMDDYYYY)	<input type="text"/>	<input type="text"/> (ICD-10)
<input type="text"/> Start Date	<input type="text"/> End Date	<input type="text"/> Quantity per Month	<input type="text"/> Diagnosis Code *
<input type="text"/> (MMDDYYYY)	<input type="text"/> (MMDDYYYY)	<input type="text"/>	<input type="text"/> (ICD-10)

SERVICES * Face-to-Face Assessment (T1023) <input type="checkbox"/> Initial <input type="checkbox"/> Modification <small>*Please attach copy of History and Physical (H&P) with Face to Face Assessment request.</small>	3-Day Individual Plan of Care (IPC) Assessment for New CBAS (H2000) <input type="checkbox"/> Initial Medical Day Care Services (S5102) <input type="checkbox"/> Initial <input type="checkbox"/> Continuation/Renewal ²	<input type="checkbox"/> Modification ² (Increase/Decrease) <input type="checkbox"/> Reinstatement Services <input type="checkbox"/> Transfer <small>²Please attach IPC, participant attendance records and transfer reason (if applicable) for continued authorization requests.</small>
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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 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 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, 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' 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 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 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 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 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 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' secure Provider Portal, which can be accessed by visiting <http://www.cahealthwellness.com/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:

Claim Entry

Gender: Male Female

Date of Birth: / / (mm/dd/yyyy)

ICD Code Set:

Click grid to enter information.
 * For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.

Line	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Qty.	Date of Service	Place of Service	Line Diag. 1	Line Diag. 2	Line Diag. 3	Line Diag. 4
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add More Procedures >>

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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' Electronic Claims/Encounter Filing Program through Centene. California Health & Wellness (through Centene) has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, California Health & Wellness (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
 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' website
- Contact the clearinghouse to inform them you wish to submit electronic claims to California Health & Wellness
- Inquire with the clearinghouse regarding what data records are required
- Verify with Provider Services at California Health & Wellness that the provider is set up in the California Health & Wellness 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, 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. 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 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' 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, all EDI claims must first be forwarded to one of California Health & Wellness' 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. 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, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to California Health & Wellness 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.

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 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. 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 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	
<p>Claim records requiring supportive documentation or attachments (i.e., consent forms)</p> <p>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.</p>	
<p>Medical records to support billing miscellaneous codes</p>	
<p>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</p>	
<p>Claim for services requiring clinical review (e.g. complicated or unusual procedure)</p> <p>Provider is required to submit medical records with the claim</p>	
<p>Claim for services requiring documentation and a Certificate of Medical Necessity (e.g. Oxygen, Motorized Wheelchairs)</p>	

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
<p>Clearinghouses Submitting Directly to California Health & Wellness</p>	<p>Emdeon SSI Gateway EDI Availity ClaimRemedi</p>
<p>California Health & Wellness Payer ID</p>	<p>68047</p> <p>NOTE: Please reference the vendor provider Manuals at www.cahealthwellness.com for their individual payer ID's.</p>
<p>General EDI Questions:</p>	<p>Contact EDI Support at (800) 225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@centene.com.</p>

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 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 PO Box 4080 Farmington, MO 63640-3835

Electronic Secondary Claims

California Health & Wellness 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 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).

The screenshot shows the California Health & Wellness website interface. At the top, there is a navigation bar with links for Home, Find a Provider, Login, and Contact, along with a search bar and a language selector. Below the navigation bar, there are three tabs: FOR MEMBERS, FOR PROVIDERS, and GET INSURED. The main content area is titled 'Member Portal' and includes a 'Login' section with a dropdown menu for 'Provider' and a 'Submit' button. Below the login section, there are instructions for creating an account and a list of benefits. A 'Provider Portal' section is also visible, providing instructions for registered providers.

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)

The screenshot shows the California Health & Wellness portal interface. At the top, there is a navigation bar with the logo and menu items: Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there is a search bar and a dropdown menu for 'Viewing Claims For:'. The main content area features a 'Choose Claim for' dropdown menu and a 'Choose a Claim Type' section. This section contains two buttons: 'CMS 1500 Professional Claim' and 'CMS UB-04 Institutional Claim'. At the bottom of the page, there are links for 'Instruction Manual (PDF)', 'Terms & Conditions', 'Privacy Policy', and 'Copyright © 2015, Centene Corporation'.

EFT and ERA

- California Health & Wellness 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 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

CARRIER INFORMATION

1. MEDICARE: MEDICAL 2. HEALTH CARE 3. OTHER 4. INSURED'S ID NUMBER (P- Prefix in Item 1)

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO 10. INSURED'S POLICY GROUP OR PICA NUMBER

11. DATE OF GROUND ILLNESS, INJURY OR PREGNANCY (MM/YY) 12. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

13. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized the release of this medical information pursuant to medical benefits to the undersigned physician or supplier for anyone else listed below)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF GROUND ILLNESS, INJURY OR PREGNANCY (MM/YY) 15. OTHER DATE (MM/YY) 16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

17. NAME OF ORDERING PROVIDER OR OTHER SOURCE 18. OUTSIDE CLERK? 19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (PMSA AL 5) (Begin on Back Sheet)

20. REVISION CODE 21. PRIOR AUTHORIZATION NUMBER

22. FEDERAL TAX ID NUMBER 23. PATIENT'S ACCOUNT NO. 24. ACCENT ASSIGNMENT 25. TOTAL CHARGE 26. AVAILABILITY 27. BILLING PROVIDER INFO & PHE

28. SIGNATURE OF PHYSICIAN OR SUPPLIER 29. SERVICE FACILITY LOCATION INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 09-38-119 / 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 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 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 at the following address:

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

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

California Health & Wellness 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 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 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 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 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 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	Tympanostomy	Disallow

DOS=01/01/10		
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
7201 0	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
7201 0	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, condyle 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	Disallow

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	Disallow

	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	
--	---	--

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
9921 5	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 problem(s) are moderate/high severity; Physicians spend 40 minutes face-to-face with patient and/or family	Allow
9924 2	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 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 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. California Health & Wellness 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 members should not be billed to the State's CHDP program, but instead should be reported on a PM-160 Information Only claim form. CHDP services require a PM160 form for the encounter to be submitted via paper submission directly to California Health & Wellness. Provision of all components of the CHDP service must be clearly documented in the PCP's medical record for each member through the use and submission of a PM160 form as an encounter. California Health & Wellness will forward to the State and retain the information on the CHDP service within the plan as required by state and federal law. Please submit PM 160s timely. Because PM 160s are currently paper forms, they can be submitted to:

California Health & Wellness
Attn: PM 160
PO Box 4080
Farmington, MO 63640-3835

Use the following link to access a copy of the PM 160 (insert hyperlink to PM 160 in forms section). For more information about the CHDP program, use the following link to a description of the [CHDP program](#).

Since the PM-160 form is recognized as an encounter form only, California Health & Wellness requires submission of a claim(s) separately for payment. Claims should be submitted as outlined in the claims submission sections of this Manual. 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.

- 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 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
 - 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
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:
 - Requests for Reconsideration should be mailed to California Health & Wellness at the address below:

California Health & Wellness
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 at the address below:

California Health & Wellness
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 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 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://wps0.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 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 Inpatient Authorization Form](#) and the [California Health & Wellness 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.
- 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 must have a properly submitted claim along with the explanation from the primary payer (EOB/EOMB or denial). California Health & Wellness will calculate the allowable amount under the plan, and subtract the amount paid. California Health & Wellness will only pay non-duplicated benefits up to a maximum of the allowable amount under California Health & Wellness or billed charges, whichever is less.

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 Preferred Drug List or requires prior authorization, please use the following link ([preferred 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 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 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

8 PATIENT NAME										9 PATIENT ADDRESS										
b DOE JANE										c										
10 BIRTHDATE	11 SEX	12 DATE			13 HR			14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28							29 ACDT STATE	30
08241980	F	060107 14 1			10			01	YO											
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN FROM THROUGH		37				38		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES			

BABY

8 PATIENT NAME										9 PATIENT ADDRESS											
b DOE BABY										c											
10 BIRTHDATE	11 SEX	12 DATE			13 HR			14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28							29 ACDT STATE	30	
06022007	M	060207 12 1			10			01	YO												
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN FROM THROUGH		37				38		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES				
42 REV CD				43 DESCRIPTION				44 HCPCS / RATE / HIPPS CODE				45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
172				NURSERY NEWBORN, LEVEL II										1		65000					

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 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 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 members. For example; if you are the PCP for a California Health & Wellness 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 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 encourage all providers to file claims/encounters electronically. California Health & Wellness has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, California Health & Wellness 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.
- 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 edits will be included in the records evaluated for compliance. Encounters that fail these edits will be rejected and California Health & Wellness 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 and a PM160 for the encounter to be submitted via paper submission directly to California Health & Wellness. 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 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 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 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 as being reasonable and medically necessary for my care. I understand that California Health & Wellness 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' 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 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 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 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 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 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. Not all members select a PCP when they enroll in California Health & Wellness. As a result, our initial priority is to make certain that every member has a PCP. All California Health & Wellness 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 approved 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

CHWP 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), such as Medi-Cal FFS utilization data. 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 FFS 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 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' 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' 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 Assessment (IHA) including a Staying Health Assessment (a DHCS-approved Individual Health Education Behavioral Assessment tool) 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 (or authorization is needed for a non-contracted PCP) and a locum tenens arrangement must be established.

Referrals

California Health & Wellness 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 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 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 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 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 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 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 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 Assessment (IHA), which includes an age-appropriate history, physical examination and Individual Health Education Behavioral Assessment (IHEBA) 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 PCP should conduct the IHA at the first health care contact and document the assessment in the medical record.
 - Providers must complete the IHEBA as part of the IHA. California Health & Wellness recommends providers use the DHCS-approved IHEBA, the Staying Healthy Assessment (SHA).
 - The SHA consists of nine questionnaires according to the appropriate age specificity (0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years, adults, 18 years and older, and seniors). Refer to the Staying Healthy Assessment section in this manual for more information.
- 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 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.

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 <i>California Board of Registered Nursing</i> .	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.

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 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 network. The specialty physician may order diagnostic tests without PCP involvement by following California Health & Wellness' referral guidelines.

Emergency admissions require notification to California Health & Wellness' 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' Medical Management Department.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from California Health & Wellness' 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 quality initiatives and programs

California Health & Wellness 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 utilizes a network of hospitals to provide inpatient and other hospital-based services to California Health & Wellness members. Hospital service providers must be qualified to provide services under the California Medi-Cal program. Hospitals must be credentialed by California Health & Wellness 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’ Medical Management Department of all admissions within one business day.
- Notify California Health & Wellness’ Medical Management Department of all specialty care nursery admits within one business day of admission.

California Health & Wellness’ 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).

Accessibility Standards and Expectations

This section contains California Health & Wellness’ key expectations and standards regarding provider accessibility. These expectations and standards help our members obtain appointments and receive services within specific timeframes.

Initial Health Assessment

For each new member, PCPs must perform an Initial Health Assessment (IHA), including a [Staying Healthy Assessment](#), which is a DHCS-approved Individual Health Education Behavioral Assessment (IHEBA) tool. 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 age 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 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.

The DHCS requires providers to administer an Individual Health Education Behavioral Assessment (IHEBA) as part of the IHA for new patients and for subsequent well care visits for current patients. The SHA should follow the SHA Periodicity Timelines found in [DHCS Policy Letter 13-001](#).

The Staying Healthy Assessment is an assessment tool that is used to administer the IHEBA. The Staying Healthy Assessment forms are accessible at the end of this Manual by using this link (SHA Forms). They are also accessible on the DHCS' website by using the following link ([Staying Healthy Assessment](#)) and are listed the heading "SHA Questionnaires". For more information about the Staying Healthy Assessment, use the following link ([SHA Training](#)) to access Staying Healthy Assessment training materials available on www.cahealthwellness.com.

Based on the member's behavioral risks and willingness to make lifestyle changes, the PCP should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP 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 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 requests that PCP’s inform our Member Services Department (“Member Services”) when a California Health & Wellness 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 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 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 in writing at least 45 days in advance of his or her inability to accept additional Medi-Cal covered persons under California Health & Wellness agreements. In no event shall any established patient who becomes a covered person be considered a new patient. California Health & Wellness 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 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 provides appropriate accessibility, availability and continuity of care to members.

Independent Practice Associations (IPAs) receive data from California Health & Wellness 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's performance goals for access-related, time-elapsd provider criteria are available for providers' reference.

California Health & Wellness Medi-Cal Plans Medical Appointment Access Standards

Appointment Type	Appointment Standard	Performance Goal
<i>PCPs and Specialists</i>		
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%
<i>Wait Time, Call Back and After-Hours Care</i>		
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	90%
Provider office telephone callback during normal business hours	Provider callback within one business day	90%

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	80%
<i>Ancillary Services</i>		
Access to non-urgent ancillary services for magnetic resonance imaging (MRI), mammogram, physical therapy	Appointment within 15 business days of request	80%
<i>Skilled Nursing</i>		
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.

Corrective Action

California Health & Wellness investigates and implements corrective action when timely access to care is not met, as required by California Health & Wellness'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 - 90% 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 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

- Each IPA is required to send in a written improvement plan (IP) to include what changes will be made for each deficiency to improve access availability. The IP must include:
 - Date the change will start for the IP.
 - Department/person responsible for implementing the change and follow-up for the IP.
 - Projected date that the IP is expected to produce outcomes that result in the access standard meeting regulatory agency time-frame compliance.
- The IPA must return the IP within 30 calendar days.

CAP Follow-Up Process

- 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.

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 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 network provider, he/she will be paid as a non-participating provider.

24-Hour Access

California Health & Wellness' 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 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' 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' 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' 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 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 member a covered services or availability of a facility;

- Providing a California Health & Wellness 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 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 members that must be followed. All marketing materials utilized by California Health & Wellness 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 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 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 or its contracted providers cannot make any written or oral statements in marketing materials that a potential member must enroll with California Health & Wellness in order to obtain benefits or not retain existing benefits.
- California Health & Wellness 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 cannot conduct marketing presentations at primary care site

Providers should not create and distribute any marketing materials to California Health & Wellness members without prior approval by California Health & Wellness, 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 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 or the member.

California Health & Wellness 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 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 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 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 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 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

California Health & Wellness 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 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' 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 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, 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 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 through the use and submission of a PM160 form as an encounter.

California Health & Wellness 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 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 care management model is designed to help your members obtain needed services from community resources, whether they are covered within the California Health & Wellness array of covered services, or from other non-covered venues. California Health & Wellness' 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 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 members that you think can benefit from the addition of a California Health & Wellness case management team member.

To contact a care manager call:

**California Health & Wellness
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 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 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 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 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 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 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](#).

A **Transplant Coordinator** provides support and coordination for members in need of major organ transplants. All members considered as potential transplant candidates should be immediately referred to the California Health & Wellness 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 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 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 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 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

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:
 - Utilize CHWP's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services;
 - File a Medi-Cal fair hearing as provided by law; or
 - Email DHCS directly at EPSDT@dhcs.ca.gov.
5. 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.

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. California Health & Wellness 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, 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 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 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 covers applied behavioral analysis (ABA) when medically necessary for California Health & Wellness 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.

MHN uses *Interqual* and MHN criteria to determine medical necessity for services. *Interqual* is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes 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.

CHAPTER 14: CREDENTIALING AND RE-CREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that California Health & Wellness 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, as well as government regulations and standards of accrediting bodies.

California Health & Wellness 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' 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 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 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 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 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 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 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 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 network.

In between credentialing cycles, California Health & Wellness 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 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' 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 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' 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 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 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 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 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 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 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 within 30 days of the change. Please contact California Health & Wellness 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 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
- 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 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 and/or a member
- File a grievance with California Health & Wellness on behalf of a member, with the member's consent

- Have access to information about California Health & Wellness quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact California Health & Wellness 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 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 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 providers, irrespective of provider type. *All* California Health & Wellness 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 until the member receives their California Health & Wellness 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' 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
- Inform members of the availability of California Health & Wellness' cultural, linguistic, and disability access services, facilitate access to these services, and immediately 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 data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by California Health & Wellness
- Comply with California Health & Wellness Medical Management program as outlined in this handbook
- Disclose overpayments or improper payments to California Health & Wellness
- 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 information regarding other insurance coverage
- Notify California Health & Wellness in writing if the provider is leaving or closing a practice
- Contact California Health & Wellness 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, 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 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 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 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 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 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 Member Services Department.
 - Conducts Group Needs Assessment - California Health & Wellness administers a group needs assessment (GNA) every five years and annually updates it. The GNA 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 Diversity & Disability Program Plan - California Health & Wellness develops and annually updates a Diversity & Disability Program Plan to address the needs identified in the GNA. The Diversity & Disability Program Plan includes goals, objectives, a timetable, and standards/performance requirements, among other things. The Diversity & Disability Program Plan 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 Committees Committee (QIC), and representatives from diverse cultural communities.

To request a copy of the most recent Group Needs Assessment or Diversity & Disability Program Plan, providers should contact California Health & Wellness’ 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 GNA 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. 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 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 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 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. 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 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; accessible formats (e.g. documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; 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 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 member, providers should contact California Health & Wellness' 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 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’ 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’ 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 pursues this objective by:

- Seeking Input from a Community Advisory Committee - California Health & Wellness 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 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’ accountability requirements should contact California Health & Wellness’ 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 is committed to ensuring that its providers and members can resolve issues through its grievance and appeals process.

California Health & Wellness 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 actively monitors its grievance and appeals process as part of its Quality Improvement program, and is committed to resolving issues within established timeframes and referring specific cases for peer review when needed.

Provider Claim Disputes

California Health & Wellness' providers are able to dispute actions or inactions by California Health & Wellness 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](#)).

Member Grievance and Appeals

California Health & Wellness 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' 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 by a provider or member about any matter other than a Notice of Action.
- An ***appeal*** is a formal request for California Health & Wellness to change an authorization decision upheld by California Health & Wellness 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 refers all members who are dissatisfied with California Health & Wellness or its subcontractors in any respect to the California Health & Wellness 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 at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number).

California Health & Wellness 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.

Expectations with Respect to Grievances and Appeals

California Health & Wellness' expectations of its member grievance and appeals process include the following important principles:

- ***Accessible and Timely Due Process*** - The California Health & Wellness conducts its grievance and appeals process in a non-discriminatory manner that promotes timely due process. In this regard, California Health & Wellness:
 - 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 member choice forms
 - Avoids labeling complaints as inquiries and funneling into an informal review

- ***Member Notification of Process*** – Upon initial enrollment, California Health & Wellness 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' Member Services Department, identifying the Grievance and Appeals Coordinators who process grievances and appeals.

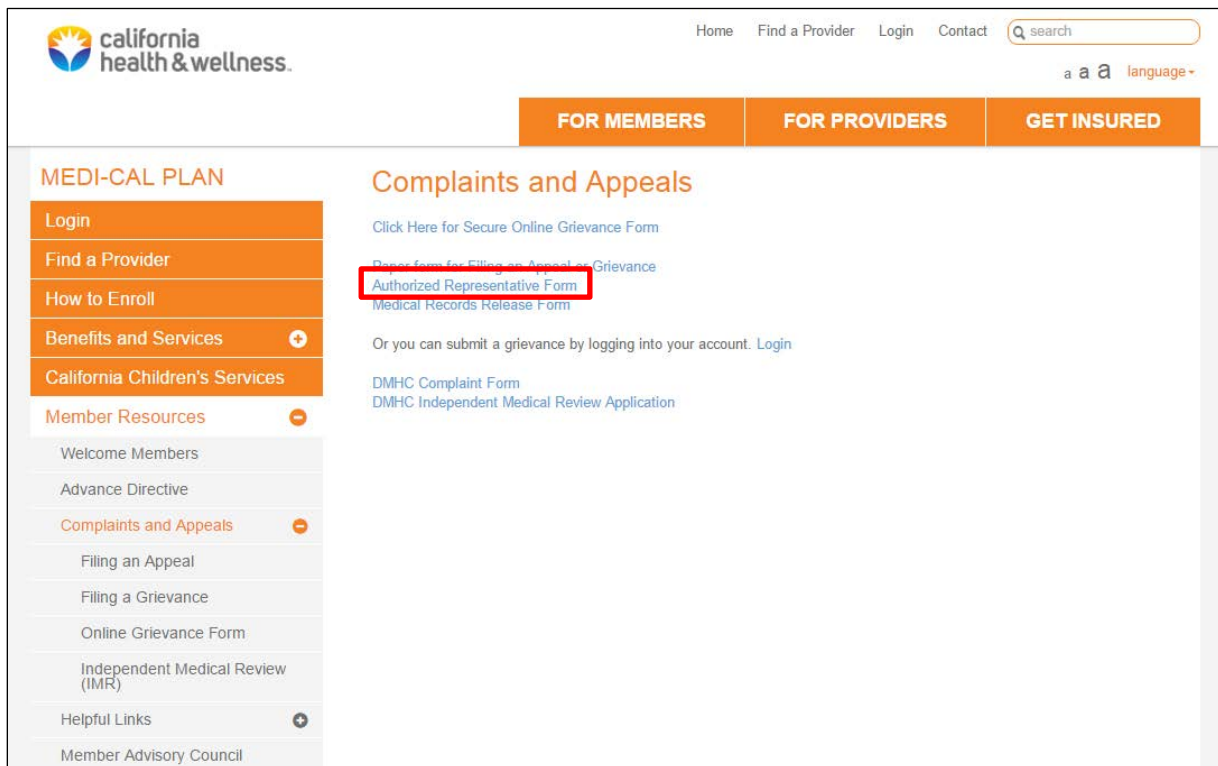
- ***Cultural, and Disability Access Needs*** - The grievance and appeals process is accessible to all members, including those with limited English proficiency or with visual or other communication disabilities. If you have a member with limited English proficiency who needs assistance in filing a grievance or appeal, please contact California Health & Wellness 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 and with the member's written consent, may file a grievance or appeal.**

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 website: <https://www.cahealthwellness.com/members/medicaid/resources/complaints-appeals.html>. To obtain a consent form, click on the “Authorized Representative Form” link.



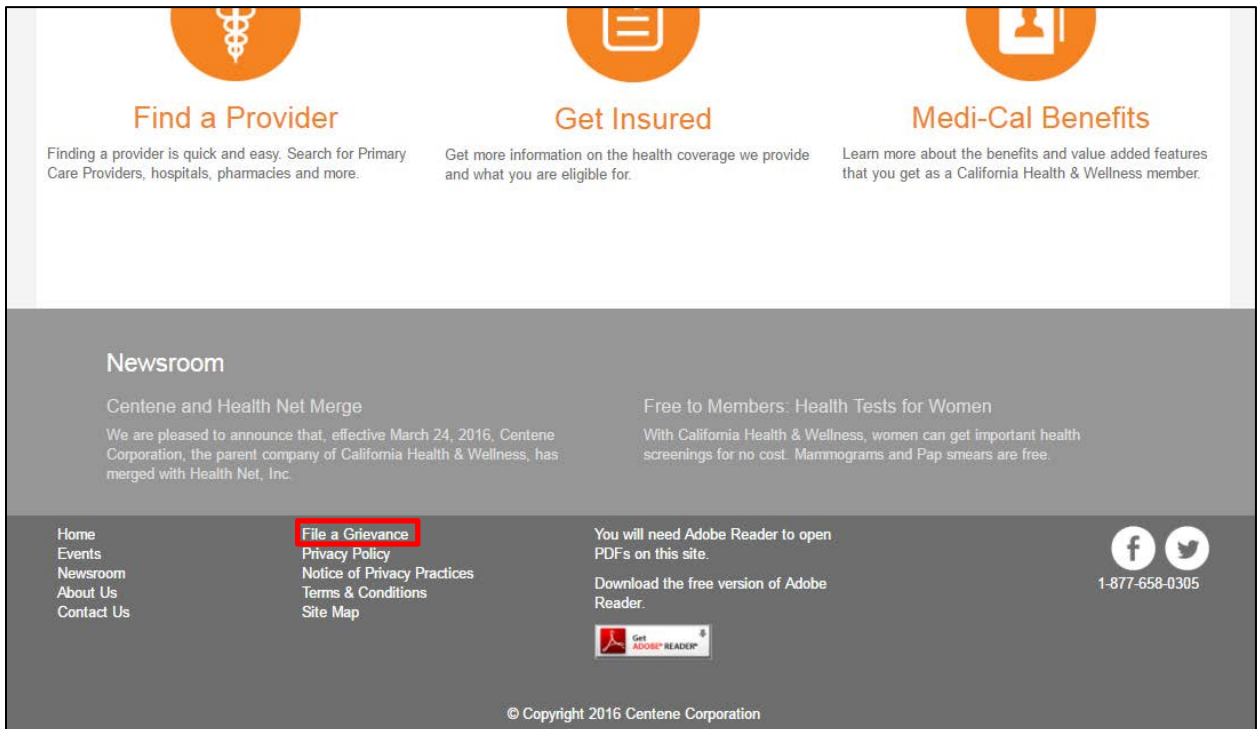
Method of Filing a Grievance or Appeal: A member, or member's authorized representative, may file a grievance or appeal verbally or in writing. California Health & Wellness furnishes members reasonable assistance in completing forms and taking other procedural steps of the Grievance System, including but not limited to the following:

- Notifying members of their right to file a grievance or request an IMR in California Health & Wellness’ 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’ 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 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 website. To submit online:

- Log on to www.CAHealthWellness.com
- On the California Health & Wellness 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 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' 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

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
Attn: Appeals and Grievance Coordinator
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833

- Investigation of a Grievance or Appeal: California Health & Wellness 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' Quality Improvement Department for investigation and resolution.

- **Making Decisions:** California Health & Wellness 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 sends resolution letters to the member within 30 calendar days from the day California Health & Wellness 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 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 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 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' 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 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, within *180 calendar days* of the incident.
- **Grievance Acknowledgement:** California Health & Wellness 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 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 received the initial grievance request, be it oral or in writing. If you have not received a response from California Health & Wellness within 30 calendar days, please contact the Grievance and Appeals Coordinator noted on the acknowledgement letter. California Health & Wellness sends a written response at the time of resolution. The written response contains a clear and concise explanation of the California Health & Wellness’ decision.
- California Health & Wellness may extend the timeframe for disposition of a grievance for up to *14 calendar days* if the member requests the extension or California Health & Wellness demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and a delay is in the member’s interest. In cases where an extension is not requested by the member and California Health & Wellness extends the timeframe, California Health & Wellness provides the member with a written notice of the reason for the delay, status of the grievance and an estimated completion date.

Expedited Review of Clinically Urgent Grievances

Overview: California Health & Wellness 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 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 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 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 receives the Appeal request (whether the Appeal was made orally or in writing).
- DHCS and DMHC Contact: DHCS may contact California Health & Wellness regarding urgent grievances 24 hours a day, seven days a week. During normal work hours, California Health & Wellness responds to DHCS and DMHC within 30 minutes after the initial contact from DHCS and DMHC. During non-work hours, California Health & Wellness responds to DHCS and DMHC within one hour after the initial contact from DHCS and DMHC. California Health & Wellness 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' 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 *90 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 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 maintains an expedited review process for appeals when California Health & Wellness 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 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 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.
- Resolution and Notice of Appeal: California Health & Wellness 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 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.
 - Under certain circumstances, detailed above in the grievance process, California Health & Wellness may provide one extension of up to 14 *calendar days*.
- Expedited Appeal Resolution and Notice: California Health & Wellness resolves expedited appeals and notifies the member regarding the decision as quickly as the member's health condition requires.

California Health & Wellness 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 receives the Appeal request (whether the Appeal was made orally or in writing).

Prior to issuing an adverse determination, the California Health & Wellness 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, 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 90 *calendar days* from the date of the notice of action 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 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 cooperates with the state agency in the hearing process and submits a copy of the member's standard appeal of California Health & Wellness' 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 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, you should first telephone us at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number) and use our 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 (1-888-HMO-2219) and a TDD line (877) 688-9891) for those with hearing and speech disabilities. The department's Internet Web site <http://www.hmohelp.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 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 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 *six months* of California Health & Wellness' written response to the member's grievance.
 - If the member, the member's provider or California Health & Wellness 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 website: [IMR](#).

- Notification: DMHC notifies the member and California Health & Wellness 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 receives a copy of the member's application for an independent medical review.

- Required Information: After California Health & Wellness is notified of the independent medical review application, California Health & Wellness provides all information related to the disputed health care service, the member's grievance and California Health & Wellness' 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' resolution of the member's grievance; and
 - California Health & Wellness' response to any additional issues raised in the member's independent medical review application.

California Health & Wellness 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 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, 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 or its providers, California Health & Wellness 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 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 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 continues providing previously authorized services that have been denied, suspended or reduced by California Health & Wellness 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 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 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' 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 continues or reinstates the member's services while an appeal or State Fair Hearing is pending, California Health & Wellness 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 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.

Cost Recovery Upon Adverse Decision to State Fair Hearing or Appeal: If the final resolution of a State Fair Hearing or an appeal is adverse to the member, California Health & Wellness may recover the costs of the services furnished while the State Fair Hearing or appeal was pending to the extent that the services were furnished solely because of the requirement to continue services during the appeal.

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' decision to deny, limit or delay services, California Health & Wellness 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' decision to deny, limit or delay services, California Health & Wellness will pay for disputed services in accordance with State policy and regulations.

CHAPTER 18: QUALITY IMPROVEMENT

Overview

California Health & Wellness is committed to continuous, measurable improvement in the delivery of quality health care for its members. California Health & Wellness' 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 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 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 are required to:

- Cooperate with California Health & Wellness in conducting all QI activities as requested. Cooperation includes the collection and evaluation of data, and participation in the California Health & Wellness' QI programs.
- Maintain the confidentiality of member information and records.
- Allow California Health & Wellness to use performance data in its reviews of quality and outcomes.

Note: California Health & Wellness 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 may use practitioner performance data for quality improvement activities. Therefore, California Health & Wellness 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 to use provider's performance data.

Through its QI program and contract with its network providers, California Health & Wellness notifies its providers that they may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

California Health & Wellness 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 serves.

Providers interested in participating on a subcommittee of the QI Committee should contact California Health & Wellness 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 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, 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 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 QI Committee. Contact your Provider Network Specialist or the Chief Medical Director at California Health & Wellness 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 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 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 also encourages provider engagement through participation in its Provider/Facility Advisory committees. If you are interested in participation in a committee please contact 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 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 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 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 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 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 and provider compliance with cultural, linguistic, and disability access requirements
- Improve other areas of needs that California Health & Wellness deems appropriate

Examples of care or services that California Health & Wellness 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 communicates activities and outcomes of its QI Program to both members and providers through the member newsletter, provider newsletter and the California Health & Wellness web Portal at www.cahealthwellness.com.

At any time, California Health & Wellness providers may request additional information on the health plan programs including a description of the QI Program and a report on California Health & Wellness 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 will either contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf or will utilize California Health & Wellness 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 requests your office's prompt cooperation with the representative so that California Health & Wellness 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, 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 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, 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 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 clinical and quality programs are based on evidence-based preventive health and clinical practice guidelines. When appropriate, California Health & Wellness 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 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:

- 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

For links to the most current version of the guidelines adopted by California Health & Wellness, 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. Print resources are sent to members within two weeks of request.

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.

California Smokers' Helpline

The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service. The Helpline offers self-help resources, referrals to local programs and one-on-one telephone counseling to quit smoking. Helpline services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese). Specialized services are available to teens, pregnant women, tobacco chewers, and e-cigarette users. CHWP offers members a 90 day regimen of all Food and Drug Administration (FDA)-approved tobacco cessation medications with at least one medication available without prior authorization. CHWP covers a minimum of two separate quit attempts per year with no mandatory break between quit attempts. CHWP also offers no cost individual, group and telephone counseling. Prior authorization is not required for members of any age even if the member decides to use tobacco cessation medications.

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 screenings, 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. 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 (CH&W). 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 accessibility review or medical record audit. Provider participation is required and is not optional. However, California Health & Wellness 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' 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 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 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 Tool: If you would like to review the Facility Site Review survey tool and scoring guidelines, please use the following link: [FSR Tool](#). The FSR guidelines are located on pages 14-39 and the FSR forms are located on pages 40-67 of the linked document.

Medical Record Review Guidelines: If you would like to see how the medical record review will be audited and scored, please use the following link: [MRR Guidelines](#). The MRR guidelines are located on page 68-77 and the FSR forms are located on pages 78-88 of the linked document.

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 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 and the DHCS at least 48 hours before cessation of operation. To notify California Health & Wellness, please contact Provider Services at (877) 658-0305 (For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number). For DHCS, please refer to the DHCS web site at <http://www.dhcs.ca.gov>.
- California Health & Wellness 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
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833

- 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 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
Attention: Contracting
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833

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 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 expires or is terminated.
- All medical records must be available for inspection or examination by California Health & Wellness, 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 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 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 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 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' contract with the California Department of Health Care Services (DHCS). California Health & Wellness successfully operates its FWA program in partnership with the Special Investigations Unit (SIU) of California Health & Wellness' parent company, Centene Corporation (Centene).

Under the FWA program, California Health & Wellness, 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 uses sophisticated code editing software to perform systematic audits during the claims payment process. California Health & Wellness 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 uncovers any of the foregoing patterns, or other patterns, California Health & Wellness will send a written communication to the provider detailing these findings. California Health & Wellness' policy is first to provide education on proper billing practices. If the pattern persists after this first step, California Health & Wellness 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' 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 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 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 Vice President of Compliance is responsible for the FWA program. California Health & Wellness 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.

Delegated providers must report any suspected case of FWA to California Health & Wellness within 10 calendar days through the FWA hotline at 1-866-685-8664. 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 at 1-877-658-0305.

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

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 Act 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 and its providers to protect the security and privacy of its members' Protected Health Information (PHI). The Act provides California Health & Wellness 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 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 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, 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 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

Misrouted PHI

Providers are required to review all member information received from California Health & Wellness 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 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' 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, a delegated entity or contractor, the provider should notify California Health & Wellness immediately upon discovery. To report a breach, call California Health & Wellness' 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 member's PHI, it is critical that the provider immediately report the breach to California Health & Wellness.

Advance Directives

California Health & Wellness is committed to making its members aware of and able to avail themselves of their rights to execute advance directives. California Health & Wellness 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 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 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 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:

<u>Provider Type</u>	<u>Category</u>	<u>Standard</u>
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** is missing from required fields
 - Example: “Statement From” or “Service From” dates
- **Type of Bill is missing or invalid** (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		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTNER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To			CPT/HCPCS	MODIFIER						
MM	DD	YY	MM	DD	YY						
7	Begin	1315	End,	1445	Time	90	minutes				NPI

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTNER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To			CPT/HCPCS	MODIFIER						
MM	DD	YY	MM	DD	YY						
ZZ	Laparoscopic	Ventral	Hernia	Repair	Op Note	Attached					NPI

Vendor Product Number- HIBCC

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.
	From	To	From	To	From	To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)						
MM	DD	YY	MM	DD	YY	MM	DD	YY	CPT/HCPCS								
VPA123	ABC7D	9E1F															NPI

Product Number Health Care Uniform Code Council – GTIN

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.
	From	To	From	To	From	To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)						
MM	DD	YY	MM	DD	YY	MM	DD	YY	CPT/HCPCS								
OZ01234	56789	1112															NPI

Universal Product Number (UPN) for contracted disposable incontinence and medical supplies

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.
	From	To	From	To	From	To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)						
MM	DD	YY	MM	DD	YY	MM	DD	YY	CPT/HCPCS								
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	(0)1234-1234-12)	01234123412
12345-123-12	(12345-0)123-12)	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 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' 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 Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B2	
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 Instructions¹

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 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 I.D. card. Do not use nicknames.	R
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 I.D. card.	C

1

FIELD#	Field Description	Instruction or Comments	Required or Conditional
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	<p>Enter the patient's complete address and telephone number including area code on the appropriate line.</p> <p>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).</p> <p>Second line – In the designated block, enter the city and state.</p> <p>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).</p> <p>Note: Patient's Telephone does not exist in the electronic 837 Professional 5010A1.</p>	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	<p>Enter the patient's complete address and telephone number including area code on the appropriate line.</p> <p>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).</p> <p>Second line – In the designated block, enter the city and state.</p> <p>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).</p> <p>Note: Patient's Telephone does not exist in the electronic 837 Professional 5010A1.</p>	Not Required
8	PATIENT STATUS		Not Required

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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9	10. IS PATIENT'S CONDITION RELATED TO: 10	11. INSURED'S POLICY GROUP OR FECA NUMBER 11	PATIENT AND INSURED INFO
a. OTHER INSURED'S POLICY OR GROUP NUMBER 9a	a. EMPLOYMENT? (Current or Previous) 10	a. INSURED'S DATE OF BIRTH 11a	
b. OTHER INSURED'S DATE OF BIRTH 9b	b. AUTO ACCIDENT? 10	b. EMPLOYER'S NAME OR SCHOOL NAME 11b	
c. EMPLOYER'S NAME OR SCHOOL NAME 9c	c. OTHER ACCIDENT? 10	c. INSURANCE PLAN NAME OR PROGRAM NAME 11c	
d. INSURANCE PLAN NAME OR PROGRAM NAME 9d	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 11d	
12. 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. 13 PERSON'S SIGNATURE _____ SIGNED _____	

FIELD#	Field Description	Instruction or Comments	Required or Conditional
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
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if # 9 is completed. Enter the policy or 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
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

FIELD#	Field Description	Instruction or Comments	Required or Conditional
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CMS 1500 Claim Form

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY	MM DD	FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ID NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	NPI	FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
		<input type="checkbox"/> YES <input type="checkbox"/> NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. _____	3. _____	
2. _____	4. _____	23. PRIOR AUTHORIZATION NUMBER

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
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

FIELD#	Field Description	Instruction or Comments	Required or Conditional
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 authorization or referral number. Refer to the California Health & Wellness 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

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

PHYSICIAN OR SUPPLIER INFORMATION

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.

FIELD#	Field Description	Instruction or Comments	Required or Conditional
24a-g Shaded	SUPPLEMENTAL INFORMATION	<p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <p>NDC, UPN,</p> <p>Anesthesia Start/Stop time & duration</p> <p>Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions.</p> <p>HIBCC or GTIN number/code.</p> <p>For detailed instructions and qualifiers refer to Appendix 4 of this Manual.</p>	C
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	<p>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.</p> <p>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.</p>	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
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

FIELD#	Field Description	Instruction or Comments	Required or Conditional
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

CMS 1500 Claim Form

25. FEDERAL TAX I.D. NUMBER SSN/EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <small>(If or govt. claims, see back)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____	a. _____ b. _____	a. _____ b. _____	a. _____ b. _____	a. _____ b. _____	a. _____ b. _____

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. 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 #	<p>Enter the billing provider's complete name, address (include the zip + 4 code), and phone number.</p> <p>First line – Enter the business/facility/practice name.</p> <p>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).</p> <p>Third line – In the designated block, enter the city and state.</p> <p>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</p>	R
33a	GROUP BILLING NPI	<p>Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI ID.</p>	R
33b	GROUP BILLING OTHER ID	<p>Enter as designated below the Billing Group taxonomy code.</p> <p>Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier.</p> <p>Atypical Providers: Enter the Medicaid Provider ID number.</p>	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. 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 or to the Medi-Cal Provider Manuals for Revenue Codes that do not require a CPT code.

Completing a CMS UB-04 Form

The image shows a screenshot of the UB-04 Claim Form. The form is titled "UB-04 Claim Form" and has various fields for patient and provider information. Numbered callouts (1-30) are placed over the form to indicate specific areas of interest:

- 1: Provider Name (Line 1)
- 2: Mailing Address (Line 2)
- 3a: Patient Control #
- 3b: Medical Record #
- 5: Federal Tax No.
- 6: Statement Covers Period From
- 7: Statement Covers Period Through
- 8a: Patient Name
- 8b: Patient Address
- 9: Patient Address (continued)
- 10: Birthdate
- 11: Sex
- 12: Date of Admission
- 13: Admission Hour
- 14: Admission Type
- 15: Source
- 16: Discharge Hour
- 17: State
- 18-21: Condition Codes
- 22-29: Additional Condition Codes
- 30: Admit State

1	(UNLABELED FIELD)	Line 1: Enter the complete provider name.	R
		Line 2: Enter the complete mailing address.	
		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	<p>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:</p> <p>1st digit - Indicating the type of facility.</p> <p>2nd digit - Indicating the type of care</p> <p>3rd digit - Indicating the billing sequence.</p>	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	R

		services must be billed using the actual date of service. (MMDDYY)	
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 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 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 Health Plan ID card. Use a comma or space to separate the last and first names. <u>Titles</u> (Mr., Mrs., etc.) should not be reported in this field. <u>Prefix</u> : No space should be left after the prefix of a name e.g. McKendrick. <u>H</u> <u>Hyphenated names</u> : Both names should be capitalized and separated by a hyphen (no space). <u>Suffix</u> : A space should separate a last name and suffix.	R
9 a-c	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.	R
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 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59	R

		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	
14	ADMISSION TYPE	<p>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:</p> <p>1 Emergency</p> <p>2 Urgent</p> <p>3 Elective</p> <p>4 Newborn</p> <p>5 Trauma</p>		R
15	ADMISSION SOURCE	<p>Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes:</p> <p>For Type of admission 1,2,3 or 5</p> <p>1 Physician Referral</p> <p>2 Clinic Referral</p> <p>3 Health Maintenance Referral (HMO)</p> <p>4 Transfer from a hospital</p> <p>5 Transfer from Skilled Nursing Facility (SNF)</p> <p>6 Transfer from another health care facility</p> <p>8 Court/Law enforcement</p> <p>9 Information not available</p> <p>For type of admission 4 (newborn):</p> <p>1 Normal Delivery</p> <p>2 Premature Delivery</p> <p>3 Sick Baby</p> <p>4 Extramural Birth</p> <p>5 Information not available</p>		R
16	DISCHARGE HOUR	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.</p> <p>00-12:00 midnight to 12:59 12- 12:00 noon to 12:59</p> <p>01- 01:00 to 01:59 13- 01:00 to 01:59</p>		C

		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	
17	PATIENT STATUS	<p>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:</p> <p>01 Routine Discharge</p> <p>02 Discharged to another short-term general hospital</p> <p>03 Discharged to SNF</p> <p>04 Discharged to ICF</p> <p>05 Discharged to another type of institution</p> <p>06 Discharged to care of home health service organization</p> <p>07 Left against medical advice</p> <p>08 Discharged/transferred to home under care of a Home IV provider</p> <p>09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)</p> <p>20 Expired or did not recover</p> <p>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)</p> <p>40 Expired at home (hospice use only)</p> <p>41 Expired in a medical facility (hospice use only)</p> <p>42 Expired—place unknown (hospice use only)</p> <p>43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital)</p> <p>50 Hospice—Home</p> <p>51 Hospice—Medical Facility</p> <p>61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed</p> <p>62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital</p> <p>63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)</p> <p>64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare</p>		R

		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

UB-04 Claim Form

31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37	
31		32		33		34		35a			36a			37	
38								39 CODE	VALUE CODES AMOUNT		40 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
								a	39		40		41		
								b							
								c							
								d							

31-34 a-b	OCCURRENCE CODE and OCCURRENCE 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	C

		<p>sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>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.</p>	
37	(UNLABELED FIELD)	<p>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.</p>	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	<p>Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>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.</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>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.</p> <p>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.</p>	C

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42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHAR
42	43	44	45	46	47	48

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	<p>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)</p> <p>Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>Please refer to your current provider contract with California Health & Wellness or to the Department of Health and Hospitals Medicaid Provider Procedures Manual</p>	C
45 Line 1-22	SERVICE DATE	<p>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</p>	C
45 Line 23	CREATION DATE	<p>Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)</p>	R
46	SERVICE UNITS	<p>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.</p>	R
47 Line 1-22	TOTAL CHARGES	<p>Enter the total charge for each service line.</p>	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

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50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	56
50		51		52	53	54		55		57	57
										OTHER PRV ID	
58 INSURED'S NAME				59 P. REL.	60 INSURED'S UNIQUE ID			61 GROUP NAME		62 INSURANCE GROUP NO.	
58				59	60			61		62	
63 TREATMENT AUTHORIZATION CODES					64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME			
63					64			65			

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 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	R

		will be the patient's name. Enter the name as last name, first name, middle initial.	
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 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

UB-04 Claim Form

The diagram illustrates the UB-04 Claim Form layout with callouts for specific fields:

- 67**: ICD-9/10-CM Principal Procedure Code (Field 74)
- 69**: Admit DX Code (Field 69)
- 70**: Patient Reason for Visit Code (Field 70)
- 71**: PPS Code (Field 71)
- 72**: ECI Code (Field 72)
- 73**: ICD-9/10-CM Other Procedure Code (Field 75)
- 74a, 74b, 74c, 74d, 74e**: Other Procedure Codes (Fields 74a-e)
- 75**: ICD-9/10-CM Other Procedure Code (Field 75)
- 76**: Attending Physician NPI (Field 76)
- 77**: Operating Physician NPI (Field 77)
- 78**: Other Physician NPI (Field 78)
- 79**: Other Physician NPI (Field 79)
- 81**: ICD-9/10-CM Other Procedure Code (Field 81)

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	R
----	--------------------------	--	---

		<p>most "V" codes are NOT acceptable as a primary diagnoses.</p> <p>Note: Claims with missing or invalid diagnosis codes will be denied</p>	
67 A-Q	OTHER DIAGNOSIS CODE	<p>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.</p> <p>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.</p> <p>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 include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.</p>	C
68	(UNLABELED)	Not Used	Not Required
69	ADMITTING DIAGNOSIS CODE	<p>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.</p> <p>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.</p> <p>Note: Claims with missing or invalid diagnosis codes will be denied.</p>	R
70 a,b,c	PATIENT REASON CODE	<p>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.</p> <p>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.</p> <p>Note: Claims with missing or invalid diagnosis codes will be denied</p>	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	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	C
		REQUIRED for EDI Submissions.	
74 a-e	OTHER PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	C
75	(UNLABELED)		Not Required
76	ATTENDING PHYSICIAN	<p>Enter the NPI and Name of the physician in charge of the patient care:</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifier and ID number</p> <p>0B – State License #</p> <p>1G – Provider UPIN</p> <p>G2 – Provider Commercial #</p> <p>ZZ – Taxonomy Code</p> <p>LAST: Enter the attending physician’s last name</p> <p>FIRST: Enter the attending physician’s first name.</p>	R
77	OPERATING PHYSICIAN	<p>REQUIRED when a surgical procedure is performed:</p> <p>NPI: Enter the operating physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifier and ID number</p> <p>0B – State License #</p> <p>1G – Provider UPIN</p>	C

		G2 – Provider Commercial # ZZ – Taxonomy Code LAST: Enter the operating physician’s last name FIRST: Enter the operating physician’s first name.	
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 # LAST: Enter the other physician’s last name. FIRST: Enter the other physician’s first name.	C
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*	<i>Increased procedural services</i>	<p>May be used with computed tomography (CT) codes when additional slices are required or a more detailed evaluation is necessary.</p> <p>Used by Local Educational Agency (LEA) to denote an additional 15-minute service increment rendered beyond the required initial service time. See <i>Local Educational Agency (LEA)</i> in the appropriate Part 2 Manual for more information.</p> <p>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.</p> <p><u>Anesthesia: Prone position, base units less than or equal to three units</u></p>
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	<p>Surgical: For use with surgery codes 66820 – 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 – 66985. Requires “By Report” documentation.</p> <p>Used by LEA to denote an annual re-assessment. See <i>Local Educational Agency (LEA)</i> in the appropriate Part 2 Manual for more information. LEA does not require “By Report” documentation.</p>
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* <u>NCCI associated</u>	Distinct procedural service	<u>Used primarily</u> with codes 36818 – 36819 and 76816. <u>Also used with other codes, as appropriate, for NCCI purposes.</u>
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* <u>NCCI associated</u>	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	<p>Used when two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the <i>Remarks</i> field (Box 80)/<i>Additional Claim Information</i> field (Box 19) of the claim.</p> <p><u>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.</u></p> <p>Also used in special circumstances as specified by the Department of Health Care Services (DHCS). For an example, refer to the <i>Surgery Billing Examples: UB-04</i> or <i>Surgery Billing Examples: CMS-1500</i> sections in the appropriate Part 2 Manual.</p>

* 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
<u>AA</u>	<u>Anesthesia performed by an anesthesiologist</u>	
AG	Primary physician	<p>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.</p> <p>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.</p> <p>Used by LEA to denote licensed physicians/psychiatrists. See <i>Local Educational Agency (LEA)</i> in the appropriate Part 2 Manual for more information.</p>
AH	Clinical psychologist	Used by LEA to denote licensed psychologists, licensed educational psychologists and credentialed school psychologists. See <i>Local Educational Agency (LEA)</i> 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 <i>Local Educational Agency (LEA)</i> 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.

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For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number.

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	
<u>DS</u>	<u>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)</u>	<u>Medical transport dry run</u>
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	<i>Same as above</i>
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.

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For TTY, contact California Relay by dialing 711 and provide the 1-877-658-0305 number.

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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
<u>GC</u>	<u>Physician services provided by a resident and teaching physician</u>	<u>Add modifier to CPT-4 codes 99201 – 99499 (Evaluation and Management Services) as appropriate.</u>
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 <i>Local Educational Agency</i> (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 <i>Local Educational Agency (LEA)</i> 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 <i>Local Educational Agency (LEA)</i> 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	<p>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.</p> <p>Use of GY only applies to medical/surgical care required for the treatment and the resolution of the acute episode.</p>

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.
<u>HN</u>	<u>Ambulance service origin code H (hospital) with ambulance service destination code N (skilled nursing facility)</u>	<u>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.</u>
HO	<i>Masters degree level</i>	Used by LEA to denote program specialists. See <i>Local Educational Agency (LEA)</i> 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	
<u>LM</u> †	<u>Left main coronary artery</u>	
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*	<i>A normal, healthy patient</i>	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	<i>Surgery, wrong body part</i>	Allowable for all procedure codes.
PB	<i>Surgery, wrong patient</i>	Allowable for all procedure codes.
PC	<i>Wrong surgery on patient</i>	Allowable for all procedure codes.
PI	<i>Positron emission tomography (PET) or PET/computed tomography (CT) to inform initial treatment strategy of tumors</i>	Allowable but not required for all radiology procedure codes.
PS	<i>PET or PET/CT to inform the subsequent treatment strategy of cancerous tumors</i>	Allowable but not required for all radiology procedure codes.
<u>PT</u>	<u>Colorectal cancer screening test; converted to diagnostic test or other procedure</u>	
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	
<u>QY</u>	<u>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</u>	
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	
<u>RI</u> †	<u>Ramus intermedius</u>	
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	<i>State-supplied vaccine</i>	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
<u>T1</u> <u>NCCI associated</u>	<u>Left foot, second digit</u>	
<u>T2</u> <u>NCCI associated</u>	<u>Left foot, third digit</u>	
<u>T3</u> <u>NCCI associated</u>	<u>Left foot, fourth digit</u>	
<u>T4</u> <u>NCCI associated</u>	<u>Left foot, fifth digit</u>	
<u>T5</u> <u>NCCI associated</u>	<u>Right foot, great toe</u>	
<u>T6</u> <u>NCCI associated</u>	<u>Right foot, second digit</u>	
<u>T7</u> <u>NCCI associated</u>	<u>Right foot, third digit</u>	
<u>T8</u> <u>NCCI associated</u>	<u>Right foot, fourth digit</u>	
<u>T9</u> <u>NCCI associated</u>	<u>Right foot, fifth digit</u>	

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
<u>TA</u> <u>NCCI associated</u>	<u>Left foot, great toe</u>	
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 <i>Local Educational Agency (LEA)</i> 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 <i>Local Educational Agency (LEA)</i> 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 <i>Local Educational Agency (LEA)</i> 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 <i>Local Educational Agency (LEA)</i> 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.
<u>TU</u>	<u>Special payment rate, overtime</u>	<u>Used by medical transportation to bill for waiting time in excess of the first 15 minutes, in one-half (1/2) hour increments.</u>
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 <i>Family Planning</i> section in the appropriate Part 2 Manual or the <i>Family PACT Policies, Procedures and Billing Instructions (PPBI)</i> 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 <i>Family Planning</i> 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 <i>Family Planning</i> 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 <i>Family Planning</i> 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 <i>Family Planning</i> 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	<p>Used by HCBS Waiver Program to separate California Community Transitions (CCT) services from other waiver services.</p> <p>Used with HCPCS code J3490 to indicate emergency contraceptive pills (levonorgestrel). See the <i>Family Planning</i> section in the appropriate Part 2 Manual or the Family PACT PPBI Manual for details.</p> <p>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.</p>
U7	Medicaid level of care 7, as defined by each state	Used to denote services rendered by Physician Assistant (PA).
U8	<u>Medicaid level of care 8, as defined by each state</u>	<u>Used with HCPCS code J3490 to indicate medroxyprogesterone acetate for contraceptive use.</u>
UA	Medicaid level of care 10, as defined by each state	<p>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.</p> <p>Also used to indicate outpatient heroin detoxification services per visit, days 1 – 7. See the <i>Heroin Detoxification Billing Codes</i> section for details.</p>
UB	Medicaid level of care 11, as defined by each state	<p>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.</p> <p>Also used to indicate outpatient heroin detoxification services per visit, days 8 – 21. See the <i>Heroin Detoxification Billing Codes</i> section for details.</p>

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 <i>Heroin Detoxification Billing Codes</i> 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	<u>Used by medical transportation to indicate that services were provided between 7 p.m. and 7 a.m.</u>
UN	Two patients served	<u>Used to indicate that two patients were served in medical transportation.</u>
UP	Three patients served	<u>Used to indicate that three patients were served in medical transportation.</u>
UQ	Four patients served	<u>Used to indicate that four patients were served in medical transportation.</u>
UR	Five patients served	<u>Used to indicate that five patients were served in medical transportation.</u>
US	Six or more patients served	<u>Used to indicate that six or more patients were served in medical transportation.</u>
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.
<u>XE</u> <u>NCCI</u> <u>Associated</u>	<u>Separate encounter: a service that is distinct because it occurred during a separate encounter</u>	
<u>XP</u> <u>NCCI</u> <u>Associated</u>	<u>Separate practitioner: a service that is distinct because it was performed by a different practitioner</u>	

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.	<p>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.)</p> <p>Use of this modifier adds \$56.63 to reimbursement. Available only to Comprehensive Perinatal Services Program (CPSP) providers. For enrollment information, see <i>Pregnancy: Comprehensive Perinatal Services Program (CPSP)</i> in the appropriate Part 2 Manual.</p>

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 <i>Evaluation and Management [E&M]</i> 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.
<u>V8</u>	<u>October 1, 2012</u>	<u>Infection present. Allowable for all procedure codes.</u>
<u>V9</u>	<u>October 1, 2012</u>	<u>No infection present. Allowable for all procedure codes.</u>
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
<u>Z1</u>	<u>Not applicable. This is an interim (local) modifier.</u>	<u>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.</u>
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 <i>Family Planning</i> 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
<u>ZS</u>	<u>August 1, 2015</u>	<u>Professional and technical component</u>
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. PM-160 Form
 - d. Provider Dispute Resolution Form
5. PCP Forms
 - a. Care Management Referral Form
 - b. Newborn Referral Form
 - c. Notification of Pregnancy Form
 - d. Staying Healthy (IHEBA) Assessment Forms
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