

Molina Healthcare of California

Medi-Cal Managed Care Provider Manual



Imperial, Los Angeles, Riverside, Sacramento,
San Bernardino, and San Diego Counties



Your Extended Family.

Introduction



Dear Provider:

Thank you for participating in Molina Healthcare of California’s (“MHC’s”) provider network and partnering with us to deliver high quality services to our members. The MHC Medi-Cal Provider/Practitioner Manual has been consolidated to now cover all counties in which MHC provides Medi-Cal managed care services:

	Imperial County	Los Angeles	Riverside	Sacramento	San Bernardino	San Diego
Geographic Managed Care				✓		✓
Two Plan Model Program	✓	✓	✓		✓	

The Manual is divided into sections stating Medi-Cal program requirements and regulatory/contractual standards to support you in providing high quality and comprehensive care to our members. Included in the Manual are references to MHC’s website at www.molinahealthcare.com where forms and prior authorization guides, in printable formats, can be accessed to fulfill your contractual requirements.

The content of this Manual is also supplemental to your Agreement with MHC. This Manual will be revised periodically, as needed. Revisions and updates to this document are made through online provider updates or written communication distributed by Just-The-Fax, the United States Postal Service or other carrier.

We appreciate and value your participation in MHC’s provider network. We look forward to continuing to partner together to provide quality, culturally sensitive and accessible healthcare services to MHC’s Medi-Cal members.

Sincerely,

Molina Healthcare of California

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1.0 CONTACTS: MOLINA HEALTHCARE OF CALIFORNIA

200 OCEANGATE, SUITE 100, LONG BEACH, CA 90802

MAIN PHONE: (562) 499-6191 TOLL FREE: (888) 665-4621 TTY: (800) 479-3310

DEPARTMENT	CONTACT INFORMATION
<p>California Children Services (CCS) / Medical Case Management: The CCS/Medical Case Management Department coordinates referrals to CCS offices and manages the coordination of health care services for members with catastrophic and/or chronic medical conditions.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621 Fax: (888) 273-1735</p>
<p>Child Health and Disability Prevention (CHDP): The Child Health and Disability Prevention Department handles all orders for PM 160s and processes PM 160s from Primary Care Practitioners.</p> <p>Online submission of PM 160: http://www.MolinaHealthcare.com</p>	<p>P.O. Box 16027 Mailstop "HFW" Long Beach, CA 90806 Attn: CHDP Department Phone: (800) 526-8196, ext. 127350 Fax: (562) 499-6117</p>
<p>Claims Department: <i>First Time Submission, Contested or Corrected Claims</i></p> <p>Molina Healthcare is responsible for processing all of its members' claims. Those Providers/Practitioners with affiliations with a Molina Healthcare-subcontracted IPA or a shared risk group should submit claims and appeals to the affiliated IPA/shared risk group per their affiliation contract.</p>	<p>P.O. Box 22702 Long Beach, CA 90801 Phone: (888) 665-4621</p> <p><u>EDI Claims:</u> Phone: (877) 469-3263</p> <p><u>Fee-For-Service Online Claim Submission:</u> http://www.MolinaHealthcare.com</p>
<p>Community Outreach: The Community Outreach staff provides outreach and organizes participation in community events such as health fairs.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 898-9892 Fax: (562) 499-6170</p>
<p>Credentialing: Credentialing Department verifies all information for Professional Review Committee approval on each Provider/ Practitioner to evaluate applicant's qualifications to be credentialed or re-credentialed. Re-credentialing is conducted at least every three (3) years.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 120117 Fax: (888) 665-4629</p>
<p>Cultural and Linguistic Services: The Cultural & Linguistic Services Department assists in the delivery of interpreter services and makes available educational materials to assist providers in delivering patient education to their Molina members.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802</p> <p><u>Interpreter Services Information:</u> Phone: (800) 526-8196, ext. 127421</p>

DEPARTMENT	CONTACT INFORMATION
<p>Department of Managed Health Care (DMHC): The Department of Managed Health Care (DMHC) is the regulatory body that licenses and oversees health maintenance organizations. DMHC accepts complaints regarding health plans by telephone. If a beneficiary has a grievance, he/she should contact the Plan and use the Plan's grievance process.</p>	<p>CA Department of Managed Health Care 980 9th Street, Suite 500 Sacramento, CA 95814-2725 Phone: (877) 525-1295 E-mail: plans-providers@dmhc.ca.gov</p>
<p>Department of Social Services (DSS): The DPSS Public Inquiry and Response unit handle inquiries from Medi-Cal beneficiaries regarding fair hearings.</p>	<p>DSS State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430 Phone: (800) 952-5253 Fax: (916) 651-5210 or (916) 651-2789 TTY/TTD: (800) 952-8349</p>
<p>Eligibility List Distribution: The Member services department is responsible for distribution of eligibility rosters (reports) on a monthly basis to all direct Primary Care Practitioners and IPA/Medical Groups.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621, option 1 Fax: (562) 901-9632</p>
<p>Eligibility Verification: The Member Services Department verifies both member eligibility and PCP assignment.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621, option 1 IVR: (800) 357-0172 Fax: (562) 901-9632</p>
<p>Encounter Data: The Encounter Data Department handles all encounters from capitated services.</p>	<p>P.O. Box 22807 Long Beach, CA 90801 Email: MHCEncounterDepartment@MolinaHealthcare.com</p>
<p>Facility Site Review: The Facility Site Review is conducted as part of PCP credentialing process. Members are not assigned until facility has passed the site review. A Periodic Facility Site Review (re-review) is conducted at the time of re-credentialing every three (3) years.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 120118 Fax: (562) 951-8325</p>
<p>Health Care Options (HCO): The Health Care Options Contractor processes Medi-Cal Managed Care enrollments and disenrollments. Please refer members to the HCO call-in number.</p>	<p>Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850 Phone: (800) 430-4263</p>
<p>Health Education: The Health Education Department assists members and providers in accessing health education and disease management programs and services (e.g., asthma, diabetes, smoking cessation, weight control).</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (866) 472-9483</p>
<p>Managed Care Ombudsman: Managed Care Ombudsman will investigate/attempt to resolve issues involving managed care plans that members have been unable to resolve through the plan.</p>	<p>Phone: (888) 452-8609</p>

DEPARTMENT	CONTACT INFORMATION
<p>Member Services: The Member Services Department handles all telephone and written inquiries from members regarding claims, benefits, eligibility/identification, selecting or changing primary care physicians, grievances, and appeals. Telephone calls are distributed to representatives via I.C.D. queue.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621 Fax: (310) 507-6186 TTY/TTD: (800) 479-3310</p>
<p>Molina Healthcare Ombudsman: The Ombudsman phone provide customers with guidance should they be unsure of how to proceed with a question, concerns or problems. The Ombudsman assist in those instances where they believe the normal Molina process has not adequately addressed their questions, concerns, or problems.</p>	<p>Molina Healthcare of California Ombudsman Program 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (877) 665-4627</p>
<p>Nurse Advice: The Nurse Advice Program is staffed during Molina Healthcare business hours and after hours by Registered Nurses for member assistance and referral.</p>	<p>Phone: (888) 275-8750 (for English) Phone: (866) 648-3537 (for Spanish)</p>
<p>Pharmacy Authorizations: The Molina Healthcare Pharmacy Authorization Desk is responsible for Molina Healthcare’s Drug Formulary inquiries and drug prior authorization requests. Requests for copies of Drug Formularies should be directed to Molina Healthcare Provider Services.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196 Fax: (866) 508-6445</p>
<p>Provider Dispute Resolutions: The Provider Dispute Resolution unit is responsible for providing a fast, fair and cost-effective dispute mechanism to process and resolve contracted and non-contracted provider disputes. Formal disputes must be submitted in writing with supporting documentation.</p>	<p>Molina Healthcare of California P.O. Box 22722 Long Beach, CA 90801 Attn: Provider Dispute Resolution Unit</p>
<p>Provider Information Management (PIM): The PIM Department is responsible for the maintenance of Molina’s Provider Network which includes all demographic updates, in addition to provider additions and terminations.</p>	<p>Fax: (562) 499-0619 Email: MHCPIM@MolinaHealthcare.com</p>
<p>Provider Education & Communications: The Provider Education Training and Communications staff informs Providers/Practitioners about Medi-Cal policies and procedures through Provider/Practitioner manuals, bulletins, newsletters, and workshops.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 127414 Fax: (562) 951-1529</p>

DEPARTMENT	CONTACT INFORMATION
<p>Provider General Information and Assistance: The Molina Healthcare Provider Services Department is the Provider/Practitioner liaison to the health plan's administrative programs. This department handles telephone and written inquiries from Providers/Practitioners regarding contracting, capitation verification, scheduling of in-service training, medical group affiliation questions, and member moves.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621</p> <p><u>Regional Local Office Numbers:</u></p> <p>Los Angeles Phone: (562) 499-6191 Fax: (562) 951-1529</p> <p>Sacramento Phone: (916) 561-8540 Fax: (916) 561-0355</p> <p>Riverside/San Bernardino Phone: (909) 430-0018 Fax: (909) 430-0071</p> <p>San Diego Phone: (858) 614-1580 Fax: (858) 5031210</p>
<p>Quality Improvement (QI): The QI Department is responsible for management and implementation of the QI Program, HEDIS and CAHPS (member satisfaction) reporting and oversight of regulatory and accreditation standards. It updates and distributes preventive care guidelines and clinical practice guidelines.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 126137 Fax: (562) 499-6185</p>
<p>Utilization Management, Referrals, & Authorization: The Medical Affairs Department conducts concurrent review on inpatient cases and facilitates referral requests for specialty care services. This includes Molina Healthcare urgent referral requests for Member who requires services within seventy two (72) hours based on urgency of member's medical condition. Authorization decision completed within seventy two (72) hours.</p> <p>Other elective referral requests for Member who requires services within two (2) weeks. Authorization decision completed within three (3) business days.</p>	<p>200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196 Fax: (800) 811-4804 (Prior Authorization) (866) 472-6303(Notification of Admissions & Concurrent Review) Clinically Urgent Referral Requests Phone: (800) 526-8196 Fax: (800) 811-4804 Elective Referral Request Phone: (800) 526-8169 Fax: (800) 811-4804</p>
<p>Vision Care: March Vision Care Group</p>	<p>Customer Service: (888) 493-4070</p>

1.1 CONTACTS: IMPERIAL COUNTY

Access to Independence of Imperial Valley

400 Mary Avenue, Suite D
Calexico, CA 92231
(760) 768-2044 phone / (760) 768-4977 fax
(760) 768-0466 TTY
www.accesstoindependence.org

Alternatives for Seniors

(888) 932-7747
www.AlternativesforSeniors.com

Area Agency on Aging (AAA)

1331 S. Clark Road, bldg. 11
El Centro, CA 92243
(800) 510-2020 or (760) 339-6450
www.co.imperial.ca.us/AreaAgencyAging/

Deaf Community Services of Imperial County

612 S J Street
Imperial, CA 92251
(760) 355-1078
www.national.citysearch.com/profile/37216891/imperial_ca/deaf_community_service.html

Health Consumer Center of Imperial Valley

449 Broadway Street
El Centro, CA 92243
(760) 353-0220 phone / (760) 353-6914 fax

In-Home Support Services (Imperial County Dept. of Social Services)

2995 South Fourth Street, suite 105
El Centro, CA 92243
(760) 337-6800 phone / (760) 337-5716 fax
www.imperialcounty.net (search for “In-Home Support Services”)

Meals on Wheels - Imperial County

1331 South Clark Road
El Centro, CA 92243
www.meals-on-wheels.org

Senior Access to Support and Services Program (SASS)

220 W. Main Street, Suite 201
Brawley, CA 92227
(800) 817-5292
(800) 539-8868 TTY
www.imperial.networkofcare.org/mh/services/agency.aspx?pid=SeniorAccesstoSupportandServicesProgram_180_2_0

1.2 CONTACTS: LOS ANGELES COUNTY

(subcontracted to Health Net)

AIDS Waiver Agency

AIDS Project Los Angeles
3550 Wilshire Boulevard, suite 300
Los Angeles, CA 90010
(213) 201-1422

Calif. Children's Services (CCS) Program

County Department of Health
9320 Telstar Avenue, suite 226
El Monte, CA. 91731
(800) 288-4584 phone / (800) 924-1154 fax

Child Health & Disabil. Prev. (CHDP) Program

City of Los Angeles (PM 160 Code: 352M)
9320 Telstar Avenue, Suite 226
El Monte, CA. 91731
(800) 993-2437 phone / (626) 569-9350 fax

City of Long Beach - Health Department

2525 Grand Avenue
Long Beach, CA 90815
(562) 570-4000

Communicable Disease Control

313 N Figueroa Street, room 212
Los Angeles, CA 90012
(213) 240-7941 phone / (213) 482-4856 fax

CPSP Perinatal Services

600 South Commonwealth, 8th Floor
Los Angeles, CA 90005
(213) 639-6427 phone / (213) 639-1034 fax

Los Angeles County Mental Health

550 South Vermont Avenue
Los Angeles, CA 90020
(800) 854-7771

Los Angeles County Public Health

phinfo@ph.lacounty.gov

Regional Centers

Eastern LA Regional Ctr (626) 299-4700
1000 S. Fremont Ave
Alhambra, CA. 91802-4700

Frank D. Lanterman Reg. Ctr (213) 383-1300
3303 Wilshire Blvd. Suite 700
Los Angeles, CA. 90010-2197

Harbor Regional Ctr (310) 540-1711
21231 Hawthorne Blvd.
Torrance, CA. 90503

North LA Regional Ctr (818) 778-1900
15400 Sherman Way, Suite 170
Van Nuys CA. 91406

San Gabriel/Pomona Reg. Ctr (909) 620-7722
761 Corporate Center Drive
Pomona, CA 91768

South Central LA Regional Ctr (213) 744-7000
650 West Adams Blvd., Suite 200
Los Angeles, CA. 90007

Westside Regional Ctr (310) 258-4000
5901 Green Valley Circle, Suite 320
Culver City, CA. 92030-1024

Substance Abuse

1000 S. Fremont Avenue, Bldg. A9 E, 3rd Floor
Alhambra, CA 91803
(626) 299-4193 phone / (626) 458-7637 fax

TB Control Program

2615 S. Grand Avenue, Room 507
Los Angeles, CA 90007
(213) 745-0800 phone / (213) 749-0926 fax

Women, Infant, & Children (WIC)

Antelope Valley: (661) 949-5805
Long Beach: (562) 570-4242
Harbor UCLA: (310) 661-3080
Irwindale: (626) 856-6600
Northeast Valley: (818) 361-7541
Pasadena: (626) 744-6520
Watts: (323) 568-3070

1.3 CONTACTS: HEALTH NET

Molina Healthcare of California is sub-contracted to Health Net in Los Angeles. If the member is a Medi-Cal beneficiary enrolled in Molina Healthcare in Los Angeles you must contact Health Net for Member Eligibility, Enrollment or Disenrollment and follow the subcontracting plan's operational procedures. However, standard Medi-Cal policies for public health program interactions, as described in this manual, apply to all contracted/participating providers. Please see important phone numbers listed below.

Community Relations (provides enrollment assistance and provider outreach)

(800) 327-0502

Fax: (818) 676-5454

Electronic Claims Submission (EDI)

(800) 977-3568

Health Net Member Services (Medi-Cal)

(800) 675-6110

Health Net Website

www.healthnet.com

(866) 458-1047 tech support (e.g. password reset, locked accounts, or other site functionality)

Health Net's website offers information on: member eligibility; claim status; reference materials (e.g. Recommended Drug List, Evidence of Coverage, and county-specific Medi-Cal Operations Manuals); forms; and contact information

Medi-Cal Claims

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

P.O. Box 14598

Lexington, KY 40512-4598

Medi-Cal Claims Disputes

Submit California Correctional Health Care Services (CCHCS) disputes at the following address:

Healthcare Invoice, Data and Provider Services Branch

PO Box 4038 - N. Freeway

Sacramento, CA 95812-4038

Pharmacy

(800) 548-5524 phone

(800) 676-8086 fax

Provider Services & 24 Hour Automated Eligibility Verification (Medi-Cal)

(800) 675-6110 phone

(800) 281-2999 fax

Email: provider_services@healthnet.com

1.4 CONTACTS: RIVERSIDE COUNTY

**Molina Healthcare of California
San Bernardino/Riverside Regional Office**

(909) 430-0018

Send correspondence to:
200 Oceangate, Suite 100
Long Beach, CA. 90802
Attn: Provider Services

AIDS Waiver Agency

Inland AIDS Project
3756 Elizabeth Street
Riverside, CA 92506
(909) 784-2437

Calif. Children's Services (CCS) Program

10769 Hole Avenue, suite 220
Riverside CA. 92505
(951) 358-5401 phone / (951) 358-5198 fax

**Child Health and Disability Prevention
(CHDP) Program**

10769 Hole Ave.
Riverside, CA 92505
(951) 358-5481
PM 160 County Code: 355

Communicable Disease Control

(951) 358-5107

CPSP Perinatal Services

308 E. San Jacinto Ave.
Perris, CA 92570
(951)210-1153 phone / (951)210-1348 fax

Regional Center

(Riverside and San Bernardino County)
Inland Regional Center
1365 S. Waterman Ave.
San Bernardino, CA 92408
Mail:
PO Box 19037, San Bernardino, CA 92423
(909) 890-3000

Riverside County Public Health

4065 County Circle Drive
Riverside, CA 92503
(951) 358-5000

Riverside Department of Behavioral Health

CARES (Community Access, Referral,
Evaluation, and Support) Line
(800) 706-7500 phone / (800) 915-5512 TTY

Substance Abuse

3525 Presley Avenue
Riverside, CA 92507
(951) 782-2400

TB Control Program

Disease Control Branch
Health Administration Building
4065 County Circle Drive
Riverside, CA 92503
(951) 358-5107

Women, Infant, & Children (WIC)

Banning: (800) 732-8805
Riverside: (800) 455-4942

1.5 CONTACTS: SACRAMENTO COUNTY

**Molina Healthcare of California
Northern Regional Administration Office**
2277 Fair Oaks Blvd., Ste. 195
Sacramento, CA, 95825
(916) 561-8540

AIDS Waiver Agency
4640 Marconi Avenue, suite 1
Sacramento, CA 95821-4316
(916) 979-7300

Calif. Children's Services (CCS) Program
9616 Micron Avenue, suite 640
Sacramento, CA. 95827
(916) 875-9900 phone / (916) 854-9500 fax

Child Health and Disability Prevention (CHDP) Program
County Department of Health
9333 Tech Center Drive, #100
Sacramento, CA. 95826
(916) 875-7151 phone / (916) 875-6731 fax
PM 160 County Code: 130

CPSP Perinatal Services
9333 Tech Center Drive, suite 800
Sacramento, CA 95826
(916) 876-7750 phone / (916) 875-6001 fax

Communicable Disease Control
7001-A East Parkway
Sacramento, CA 95823
(916) 875-5471 phone / (916) 875-4069 fax

HIV Prevention and Education
(916) 875-6022

Regional Center
Alta California Regional Center
2241 Harvard Street, Suite 100
Sacramento, CA 95815
(916) 978-6400

Sacramento County Behavioral Health
7001-A East Parkway, suite 400
Sacramento, CA 95823
(916) 875-7070 phone / (916) 875-6970 fax
(888) 881-4881 24 hour info line

Sacramento Public Health
(916) 875-5881

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Sacramento Department of Health and Human Services
2251 Florin Road #100
Sacramento, CA. 95822
(916) 427-5500

Substance Abuse
Alcohol and Drug Services Division
(916) 874-9754

TB Control Program
Primary Care Center, Chest Clinic
4600 Broadway
Sacramento, CA 95820
(916) 874-9670

Women, Infant, & Children (WIC)
Sacramento: (916) 326-5830 or (916) 876-5000

1.6 CONTACTS: SAN BERNARDINO COUNTY

**Molina Healthcare of California
San Bernardino/Riverside Regional Office**

(909) 430-0018

Send correspondence to:
200 Oceangate, Suite 100
Long Beach, CA. 90802
Attn: Provider Services

Calif. Children’s Services (CCS) Program

150 Carousel Mall
San Bernardino, CA 92415
(909) 387-8400 phone / (909) 387-8401 fax

**Child Health and Disability Prevention
(CHDP) Program**

120 Carousel Mall
San Bernardino CA 92415
(909) 387-6499 phone / (909) 387-6348 fax
PM 160 County Code: 356

Communicable Disease Control

351 N. Mountain View Avenue
San Bernardino, CA 92415
(800) 722-4794 phone / (909) 387-6377 fax

CPSP Perinatal Services

120 Carousel Mall
San Bernardino, CA 92415-0028
(909) 388-0104 phone / (909) 388-0462 fax

Regional Center

(Riverside and San Bernardino County)
Inland Regional Center
1365 S. Waterman Ave.
San Bernardino, CA 92408
Mail:
PO Box 19037, San Bernardino, CA 92423
(909) 890-3000

San Bernardino County Public Health

351 N. Mt. View Avenue
San Bernardino, CA 92415
(800) 782-4264 phone / (909) 387-6359 TTY

San Bernardino Behavioral Health

Phoenix Community Counseling
820 E. Gilbert Street
San Bernardino, CA 92415
(909) 387-7200 phone / (909) 387-7717 fax

Substance Abuse

Phoenix Community Counseling
820 E. Gilbert Street
San Bernardino, CA 92415
(909) 387-7200 phone / (909) 387-7717 fax

Women, Infant, & Children (WIC)

Banning: (800) 732-8805
San Bernardino: (855) 424-7942

1.7 CONTACTS: SAN DIEGO COUNTY

Molina Healthcare of California
San Diego Regional Office
(858) 614-1580
9665 Chesapeake Dr. Ste. 305
San Diego, CA 92123

AIDS Waiver Agency
150 Valpreda Road, suite 211
San Marcos, CA 92069
(760) 736-6725

Calif. Children's Services (CCS) Program
County Department of Health
6160 Mission Gorge Road
San Diego CA. 92120
(619) 528-4000 phone / (619) 528-4087

Child Health and Disability Prevention (CHDP) Program
3851 Rosecrans Street
San Diego, CA. 92110
(619) 692-8808 phone / (619) 692-8827 fax
PM 160 County Code: 013
Mail: PO Box 85222, San Diego, CA 92186

Communicable Disease Control
(619) 692-8499 or (858) 565-5255

CPSP Perinatal Services
3851 Rosecrans Street, suite 522
San Diego CA 92110
(619) 542-4053 phone / (619) 542-4045 fax

Regional Center
4355 Ruffin Road, suite 200
San Diego, CA. 92123
(858) 576-2996

San Diego Behavioral Health
(888) 724-7240

San Diego County Public Health
(619) 531-5800

Substance Abuse
Office of Alcohol and Drug Services
(619) 584-5007

TB Control Program
(619) 692-5565

Women, Infant, & Children (WIC)
Chula Vista: (619) 426-7966
San Diego: (800) 500-6411
San Marcos: (760) 471-2743
SDSU: (888) 999-6897

2.0 ELIGIBILITY, ENROLLMENT, DISENROLLMENT

ELIGIBILITY FOR MANAGED CARE

Mandatory Aid Categories

Under the Geographic Managed Care (GMC) and Two-Plan Model, enrollment is mandatory for the following aid categories eligible for Medi-Cal without a share-of-cost:

- CalWorks - formerly Aid to Families with Dependent Children (AFDC)
- CalWorks - formerly Medically Needy, Family (AFDC)
- Medically Indigent Children
- Refugee/Entrant
- Public Assistance, Family

Voluntary Aid Categories

Beneficiaries who fall into these aid categories may enroll but are not required to do so:

- Public Assistance, Aged
- Public Assistance, Blind/Disabled
- Medically Needy, Aged (no share-of-cost)
- Medically Needy, Blind/Disabled (no share-of-cost)
- Medically Indigent Adult

Exemptions from Mandatory Enrollment

Medi-Cal beneficiaries meeting the following criteria are exempt from mandatory enrollment:

- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a provider(s)/practitioner(s) or who are not participating in the GMC or Two-Plan Model provider/practitioner network.
- Children in Foster Care or the Adoptions Assistance Program.*
- Native Americans, their household members, and other persons who qualify for services from an Indian Health Center.*

Not Permitted to Enroll

Medi-Cal beneficiaries meeting the following criteria are not permitted to enroll under the GMC Program and Two-Plan Model:

- Individuals in a skilled nursing facility.
- Individuals with the following other health coverage:
 - Kaiser HMO
 - CHAMPUS
 - Other HMO coded K, F, C, or P
 - Medicare HMO (unless it is also a Geographic Managed Care Plan, and the Department of Health Care Services allows this plan to enroll beneficiaries in both the contractor's Medicare HMO and Medi-Cal managed care plan)

* These individuals are exempt from mandatory enrollment, although if they wish to enroll they may do so.

NEW MEMBERS

Molina Healthcare (MHC) receives a weekly enrollment tape from Health Care Options (HCO) and a monthly Central Insurance Division (CID) Medical Eligibility Data System (MEDS) tape from DHCS. The data received from HCO is matched to the CID MEDS Monthly File and loaded into MHC's computer system in order for the new member enrollment records to receive eligibility. This process creates a new member file for eligibility purposes and production of member identification cards. Each new member receives a MHC Welcome Packet that includes a MHC identification card. This identification card will contain the name of the member's Primary Care Practitioner (PCP). To identify a member's assigned PCP, you may also refer to MHC's Interactive Voice Response system or the Plan's Member Services Department. The identification card issued by MHC is for Plan Identification only. Although the member eligibility is verified at the time the card is issued, possession of the card does not guarantee eligibility. In case a member has lost the identification card or his/her eligibility is in question, eligibility may be verified using one of the following options:

- PCP eligibility roster
- Molina Healthcare Interactive Voice Response at (800) 357-0172 [also accessible through (888) 665-4621]
- Automated Eligibility Verification System (AEVS) at (800) 456-2387¹
- Point of Service Device (POS)²
- Data entry through C.E.R.T.S. software (Claims & Eligibility Real Time System)³
- MHC's Member Services Department at (888) 665- 4621
- MHC's Provider Resolution Department at (888) 665-4621
- MHC's Web Portal (www.MolinaHealthcare.com)

If the member does not appear on the current eligibility roster, the Provider/Practitioner should contact MHC's Provider Services Department at (888) 665-4621.

At no time should a member be denied services because his/her name does not appear on the eligibility roster. Please remember that a member may access emergency services without prior authorization.

Remember, the card is for identification purposes only. Eligibility to receive services depends on verification from MHC. There will be at least two (2) phone numbers on the front of the card. The first number is for members to use. If a member has questions that you are unable to answer, suggest a call to MHC's Member Services Department.

¹ Providers/Practitioners who would like to obtain a PIN number in order to access AEVS may call (800) 541-5555.

² Providers/Practitioners who would like to obtain a POS Device may call (800) 541-5555.

³ Providers/Practitioners who wish to obtain C.E.R.T.S. software may call (800) 541-5555.

ELIGIBILITY VERIFICATION

Ask the member for his/her plastic Medi-Cal Benefits Identification Card (BIC) issued by DHCS with the magnetic strip. Providers/Practitioners who have access to POS devices may swipe the member's Medi-Cal BIC card through the device to get information about the member's current or past eligibility status, the current or past PCP's name and phone number, or capitated IPA/Medical Group and phone number. The CERTS software and AEVS verification systems provide the same information. If help is needed in using the POS Device, call the POS Help Desk at (800) 541-5555.

The MHC Interactive Voice Response (IVR) system notifies both Providers/Practitioners and members of member eligibility status and PCP assignment. The system has a dedicated phone line at (800) 357-0172 and is available twenty four (24) hours a day, three hundred sixty five (365) days a year. The system provides members' last name, first name, date of birth, eligibility status, and PCP information, as well as IPA/Medical Group affiliation and subcontract health plan affiliation as applicable.

In the event that the IVR System is not working, the Plan's alternative is MHC's Web-Portal: www.MolinaHealthcare.com or MHC's Member Services Department. The Provider/Practitioner may verify eligibility directly with MHC staff at (888) 665-4621. The Eligibility Department is staffed Monday through Friday, 7:00 a.m. to 7:00 p.m. Any calls made during non-business hours go directly to MHC's after hour service, with the same access to current member eligibility status.

ELIGIBILITY REPORTS

MHC distributes eligibility reports monthly to provide information on member enrollment in an IPA/Medical Group or with a directly contracted PCP or Direct PCP Groups. The reports are generated the first week of each month and mailed to IPAs/Medical Groups, PCPs, and to Direct PCP Groups.

MHC Healthcare members who have changed Providers/Practitioners by the 25th of a month will be listed on the next month's eligibility reports. Members who have changed Providers/Practitioners after the 25th of a month will be listed on the month following the next month's eligibility listing.

MHC's hard copy (paper) eligibility reports are titled "Eligibility Listing-IPA Roster." This report is mailed to IPA/Medical Groups, Providers/Practitioners, and/or staff model facilities on a monthly basis, on or before the 10th of the mid-month.

MHC's electronic export file of the eligibility report is titled "Molina Healthcare Eligibility Listing: <IPA Name> Roster - <Month> and <Year>". As directed by the IPA/Medical Group, the electronic file is sent via electronic mail, diskette, or via US mail to the IPA/Medical Group designee by the 10th of each month. These files are password protected and can only be accessed by the IPA/Medical group designee.

The reports include the following information:

Member First and Last Name, Member Telephone Number, Social Security Number, and Client Identification Number (CIN), MEDS ID, Date of Birth, Enrollment Effective Date, Enrollment Termination Date, PCP Effective Date, PCP Termination Date, County/Project Code, Member's Complete Address, Member's Change or Drop Reason, and Status of Enrollment.

[Each asterisk (*) represents thirty (30) days in the health plan. For example, a member with two asterisks (**) signifies sixty (60) days the member has been on plan. When a member reaches one hundred twenty (120) days on plan, the asterisks will no longer appear on eligibility report.]

The report contains the following sections:

- **NEW MEMBER** - list of all NEW members assigned.
- **MEMBERS WHO TRANSFERRED IN** - list of members who have requested a PCP change to your facility along with the name and phone number of the previous PCP to assist you in obtaining the member's medical record.
- **MEMBERS WHO TRANSFERRED OUT** - list of members who requested a change of PCP.
- **MEMBERS WITH AN ENROLLMENT RESTRICTION** - list of members assigned to your facility, BUT NOT eligible at the time the eligibility roster was printed. IT IS IMPORTANT THAT YOU VERIFY CURRENT DAY ELIGIBILITY for these members on your POS SYSTEM, AEVS, or by telephoning MHC's automated eligibility system at (800) 357-0172.
- **MEMBERS DROPPED FROM THE PLAN** - list of members who have dropped from plan.
- **MEMBER MODIFICATION** - list of members who have a change of address, Medical Identification Number, or 14-digit MEDS ID number.
- **CONTINUING MEMBERS** - list of members who have continuously been assigned
- **MEMBER ENROLLMENT Initial Health Assessment (IHA)** - identifies the time-frame that a member has been on the Plan for up to four (4) months from his/her initial date of eligibility. An asterisk (*) is equal to each month the member has been on the Plan. The asterisk will assist you in identifying members in need of his/her Initial Health Assessment. MHC's IHA access standards are as follows:
 - Within one hundred and twenty (120) days for members under 18 months
 - Within one hundred and twenty (120) days for members over 18 months

If a member arrives at a PCP's office to receive care, but does not appear on the current month's eligibility report, the office should contact MHC to verify eligibility. However, a member must not be denied services because his/her name does not appear on the eligibility roster.

ENROLLMENT

Health Care Options (HCO) is responsible for providing Medi-Cal beneficiaries information pertaining to the benefits of health care services through a managed care plan. HCO also assists the beneficiary in making choice among the different managed care plans. HCO is responsible for assigning beneficiaries who fail to choose a health plan to a managed care plan within each beneficiary's county. HCO is responsible for the distribution of enrollment forms to

beneficiaries as well as to the various managed care health plans. The health plans then distribute the forms to their prospective members upon request. The health plans and their affiliated Providers/Practitioners are no longer allowed to submit the Medi-Cal Enrollment Forms on behalf of their patients.

ENROLLMENT PROCESS

Initial Eligibility and Annual Re-Determination

The following process was created to ensure a smooth transition for all Medi-Cal beneficiaries:

- HCO mails an enrollment packet to each beneficiary who did not attend an HCO presentation. The packet includes an Enrollment Form, Provider Directories, Health Plan Comparison/Feature Charts, and a Medi-Cal Choice Booklet.
- Beneficiaries must select a health plan within their county and complete and mail the enrollment form to HCO within thirty (30) days from the date on which they received the packet.
- Once HCO receives the enrollment form, the beneficiaries' information is entered into their system. If the beneficiary failed to select a health plan, HCO will assign a health plan to the member.
- A beneficiary will be notified by HCO in writing of the auto assignment to a managed care health plan at least thirty (30) days prior to the final submission of documents to DHCS. If the beneficiary wishes to enroll in a different managed care health plan after the submission has been made to DHCS, he/she must contact HCO at (800) 430-4263 to enroll into the managed care health plan of his/her choice.
- If a beneficiary selects a health plan, but not a Primary Care Practitioner (PCP), the health plan will automatically assign a PCP to him/her through the auto assignment process described below.

If beneficiaries have questions regarding the enrollment process, they should be directly referred to HCO at (800) 430-4263.

PCP AUTO ASSIGNMENT

Upon initial enrollment, if the member did not select a PCP, MHC will assign a PCP to the member and mail out an ID card with the Welcome Packet indicating PCP assignment. The Welcome letter explains to the member that they may select a different PCP if they are dissatisfied with the choice made for them. The letter also advises members of the importance of scheduling an appointment with their PCP within the first ninety (90) days of initial enrollment.

The following criterion is followed when processing auto assignment of a PCP:

- The proximity of the provider/practitioner must be within ten (10) miles or thirty (30) minutes of member's residence.
- The member's language preference.
- The member's age, gender, and special PCP needs (i.e., Pediatrician, Obstetrician, etc.)
- The existence of established relationships and family linkages.

- MHC makes every attempt to assign members to the PCP of their choice. MHC is limited to the information that is on the HCO tape, which is neither always complete nor correct.

DISENROLLMENT PROCESS

Any member of MHC may at any time, without cause, request to be disenrolled from the plan. The member must contact HCO at (800) 430-4263. A HCO representative will mail a disenrollment form to the member's residence. A member with a mandatory aid code must simultaneously re-enroll into another managed care health plan. If the member fails to select a health plan, HCO will automatically assign him/her to one. Members who have a voluntary aid code may elect to remain in the Medi-Cal Fee-for-Service program or select a new health plan.

The disenrollment process takes fifteen (15) to forty five (45) days to complete. During this time period, MHC will be responsible for the member's health care until the disenrollment is approved by DHCS and processed by HCO.

Disenrollment of a member is mandatory under the following conditions:

- Member requests to be disenrolled.
- Member loses Medi-Cal eligibility.
- Member moves out of the Plan's approved service area.
- Member's Medi-Cal aid code changes to an aid code not covered.
- Member's enrollment violates the State's marketing and enrollment regulations.
- Member requests disenrollment as a result of a Plan merger or reorganization.
- Member is eligible for those carve-out services that require disenrollment. (See Additional Services or Carve-Out Services).

Members disenrolled because of any of the above conditions will be allowed to return to the Fee-for-Service Medi-Cal Program unless their Medi-Cal eligibility is a mandatory managed care aid code or eligibility is terminated by DHCS. MHC does not determine eligibility for the Medi-Cal program. DHCS allows for certain beneficiaries to remain in Fee-for-Service Medi-Cal as described above, under the Heading, Exemptions from Mandatory Enrollment. Such exemptions are granted by HCO and DHCS, not MHC. For more information, contact HCO at (800) 430-4263.

PROVIDER/PRACTITIONER PLAN INITIATED DISENROLLMENTS (PID)

A Provider/Practitioner may request to DHCS that a Plan Initiated Disenrollment (PID) be processed for any of its members. However, the health plan is responsible to initiate the process with DHCS. All written communication letters sent to the members must be prior approved by the Plan and/or DHCS.

The Provider/Practitioner contracted with MHC must make its requests in writing and forward such requests to MHC's Member Services Department, Attn: Member Services Director. These requests must include a detailed description of the circumstances prompting the Provider/Practitioner to initiate the request for disenrollment. Included should be any

documentation and detailed description of corrective action taken by the Provider/Practitioner in an effort to resolve the matter. The detailed description should include:

- Statement of the specific issue
- Dates of occurrence
- Frequency of occurrence

Upon receipt of such request from the Provider/Practitioner, the Member Services Department Director or designee will make an effort to contact the member to provide education and counseling. Member Services will involve a Case Manager to attempt to coordinate care. The member may be transferred to another PCP within the plan. In every case, the member is notified in writing of the intent to disenroll and given a thirty (30) day opportunity to appeal to the Member Services Department or DHCS fair hearing via telephone or in writing. At no time should the Provider/Practitioner contact the member without approval of the Member Services Department Director or designee. The Member Services Department Director or designee will then review the request with the Plan's Medical Director and process a PID request to DHCS for approval. Once DHCS reviews the request; the member is mailed a letter, via U.S. mail, notifying him/her of the outcome.

MHC is responsible to notify the member via certified mail that the Plan has been notified of their behavior. The member will be warned that further non-compliance may result in transferring the member to an alternate Provider/Practitioner or termination of membership from the plan based on the severity of the issue. If the member fails to comply and behavior is repeated, the Provider/Practitioner must immediately send documentation of repeated offense to MHC Member Services. The Provider/Practitioner is responsible for sending final documentation to the Plan. MHC must notify the member again (second and final notification) in writing via U.S. certified mail of MHC's intent to request a PID or transfer to an alternate Provider/Practitioner. The provider will receive a cc copy of the letter for their medical records.

A PID is evaluated on the severity and cause of the breakdown of the Provider/Practitioner/member relationship. Below are examples of circumstances that could result in a PID. To initiate a PID, the documentation process outlined above must be followed.

DHCS will approve a request only if one or more of the following circumstances have occurred:

- The member is repeatedly verbally abusive to Plan Providers/Practitioners, ancillary or administrative staff, or to other Plan members.
- The member physically assaults a Plan Provider/Practitioner, staff member, or Plan member, or the member threatens any individual with any type of weapon on the Plan premises. In such cases, appropriate charges must be brought against the member, and a copy of the police report should be submitted along with the request.
- The member is disruptive to Provider/Practitioner operations in general with potential limitation of access to care by other patients.
- The member habitually uses non-contracted Providers/Practitioners for non-emergency services without prior authorization.
- The member has allowed the fraudulent use of his or her health plan identification card.
- The member refuses to transfer from a non-Plan hospital to a Plan hospital when it is medically safe to do so.

- Other inappropriate use of out-of-plan services that result in degradation in the Plan's relations with community Providers/Practitioners thereby threatening the access of other Plan members.

A member's failure to follow prescribed medical care treatment, including failure to keep established medical appointments, does not warrant a request for a PID unless MHC can demonstrate to DHCS that, as a result of such failure, the Plan or Provider/Practitioner is exposed to greater and unforeseeable risk. In this event, a temporary PID may be requested by the Plan and granted by DHCS.

Expedited Disenrollment Requests

The Plan may request for an expedited disenrollment for the following:

- **Continuity of Care** - If the treating Provider/Practitioner is not part of MHC's network of Providers/Practitioners, the member may be eligible for disenrollment. The member is only eligible for disenrollment within the first ninety (90) days of initial enrollment with MHC. A medical exemption form signed by the treating Provider/Practitioner and member is required for processing.
- **Long Term Care** - The member must be in a Skilled Nursing Facility (SNF) longer than the month of admission and one month after. MHC must have the date of admission, name, address, telephone, and fax number of the facility.
- **Incarceration** - The name of the facility and the date the member entered the facility is required for processing.
- **Resides Outside-of-the-Service Area** - The member moved outside of the service area. The member's new address and move date is required. The member must report their change of address to their eligibility worker within ten (10) days. Failing to do so will result in delaying the disenrollment from MHC.
- **Native American** - If the member is a Native American the member may be exempted from being in a health plan. A Non-Medical Exemption form must be completed by an Indian Health Service Provider/Practitioner. The form is required for processing.
- **Major Organ Transplant** - The member must be approved for a transplant and the Treatment Authorization Form (TAR) must be provided to MHC's Member Services Department for processing.

All requests for expedited disenrollments along with any required documentation must be submitted to MHC's Member Eligibility Supervisor via facsimile at (562) 901-9632 or US Mail. The member may also initiate a request by calling MHC's Member Services Department at (888) 665-4621. If you need copies of the exemption forms mentioned, please contact HCO at (800) 430-4263.

Molina Healthcare of California
 Attn: Member Eligibility/Outreach Supervisor
 200 Oceangate, Suite 100
 Long Beach, CA 90802
 Fax: (562) 901-9632

Related Policies-For more information or a copy of the complete PID policy, contact MHC's Member Services Department at (888) 665-4621.

3.0 BENEFITS AND COVERED SERVICES

PRINCIPAL BENEFITS AND COVERAGES

The following benefits and services are available for prevention, diagnosis, and treatment of illness or injury (including ancillary services). Please contact Provider Services for information, principal benefits, and coverage according to contract and service area at (888) 665-4621.

Provider/Practitioner Services

The following services are covered as medically necessary:

- Routine adult and pediatric examinations
- Specialist consultations
- Injections, allergy tests, and treatments
- Physical, speech, and occupational therapy*
- Provider/Practitioner services in or out of the hospital
- Podiatry services^
- Audiology services^

Inpatient Hospital Services

- Room and board in a semi-private room, or if medically necessary, in a private room
- Surgical procedures
- Anesthesia
- Laboratory and x-ray, including radiation therapy
- Use of operating room, special cardiac care units, intensive care, or recovery room
- All other medically necessary hospital services, including medications and nursing services

Laboratory Services

The following are provided for diagnosis and/or treatment:

- Laboratory tests
- X-ray procedures
- Other tests as deemed medically necessary, such as electrocardiograms and electroencephalograms

Home Health Care

The following are provided in the home when medically necessary:

- Intermittent skilled nursing services
- Intermittent ancillary services

* These services may be provided through a carve-out program such as CCS or through Regional Center Services. Please see Section 7:3, titled “Healthcare Services: Pediatric and Child Health Services” and Section 7:4, titled “Healthcare Services: Waiver Programs” in this Manual for more information.

^ There are exceptions for the services noted with a caret. Please see the paragraph titled “Exceptions for Services Not Covered by Molina Healthcare or Regular Medi-Cal.”

Preventive Health Services

- Newborn and well-baby care (newborn care is limited to the month of birth and the following month when delivered by the mother during her enrollment with the Plan)
- Periodic health examinations
- Child Health and Disability Prevention (CHDP) services
- Medically required immunizations
- Sexually transmitted diseases (STD) tests
- Health education services

Prescription Drugs

- Drugs administered during an inpatient stay or at medical offices or emergency rooms
- Formulary Drugs prescribed by a plan Provider/Practitioner and filled at a participating pharmacy

Emergency Care

- Provider/Practitioner, hospital, and emergency room care for accident or other illness

Ambulance Service

- Provided for emergency transportation situations

Extended Care in Skilled Nursing Facility

Services provided when medically necessary include:

- Room and board
- Provider/Practitioner and nursing services
- Prescription drugs
- Injections
- Ancillary Services

Long-Term Care (LTC) coverage is limited to the month of admission and the following month. Members return to the Fee-for-Service (FFS) Medi-Cal program for continued LTC coverage after this period. To ensure continuity of care, the Provider/Practitioner will continue to provide and coordinate the care for potential LTC candidates until the member is disenrolled from MHC. MHC's Member Services Department is responsible for submitting requests for mandatory disenrollment to the appropriate agencies and for coordinating with the Utilization Management Departments of MHC and its affiliates.

Hospice Care

- The hospice benefit is for people who are diagnosed with a terminal illness and who choose hospice care instead of the traditional services covered by the plan. Please contact MHC for further information.

Maternity Care

- Provider/Practitioner or Nurse Midwife Services
- Prenatal and post-partum care

Inpatient Hospital Services

- Semi-private accommodations including all hospital services for mother and child

Family Planning

- Contraceptive pills
- Contraceptive devices (IUD, Depo Provera, Norplant, diaphragm)
- Vasectomy and tubal ligation
- Pregnancy testing and counseling

Other Medical Services

- Prosthetic and orthotic devices
- Durable medical equipment (DME)
- Hearing aids and eyeglasses
- Blood and blood plasma
- Chronic hemodialysis
- Therapeutic and elective pregnancy termination
- Renal and corneal transplants
- Community Based Adult Services (CBAS)
- Mental Health Services - the extent of covered services are described in the “Healthcare Services” section of this Manual
- Alcohol and Drug Treatment - the extent of covered services are described in the “Healthcare Services” section of this Manual
- Chiropractic Services - with prior authorization, up to (2) two treatments per calendar month. (GMC only)
- Dental Services (screening) - the extent of covered services are described in the “Healthcare Services” section of this Manual
- Acupuncture Services - with prior authorization up to (2) two treatments per calendar month, acupuncture is covered when all other therapies have been tried and failed (GMC only)

Vision Services

- Eye examinations
- Glasses[^]
- Contact lenses (when medically necessary)[^]

PRINCIPAL EXCLUSIONS AND LIMITATIONS

Exclusions

The following benefits and services are excluded from coverage.

Services that are not covered by Molina Healthcare or Medi-Cal

These services will not be provided by MHC or Regular Medi-Cal (fee-for-service program):

- Experimental procedures (unless approved)

[^] There are exceptions for the services noted with a caret. Please see the paragraph titled “Exceptions for Services Not Covered by Molina Healthcare or Regular Medi-Cal.”

- Over-the-counter (OTC) drugs (unless approved)
- Cosmetic surgery, except when required to repair trauma or disease-related disfigurement
- Personal comfort or convenience items
- Private duty nurses (except when medically necessary)
- Elective circumcisions
- Sports physicals required by school or recreational sport
- Completing forms for disability, WIC, DMV
- Services outside the United States except Emergency Room Services needing inpatient stay in Canada and Mexico
- Psychology Services (psychiatry services, and all services through county mental health programs will continue to be covered)^
- Audiology Services not performed/prescribed by a provider in a provider office^
- Speech Therapy Services^
- Podiatry Services^
- Dental Services^
- Acupuncture and Chiropractic Services for GMC Counties (San Diego and Sacramento only) - limited to excepted members [this is not a benefit for Two Plan (Riverside/San Bernardino) members – no exceptions]^

Excluded (Carve-Out) Services

Medi-Cal beneficiaries enrolled in a managed care plan obtain most of their benefits from their health plan. Medi-Cal services not covered by the plan are referred to as “excluded” or as “carve-out.” These services can only be rendered by a Medi-Cal enrolled Provider/Practitioner and must be billed through the Medi-Cal Fee-for-Service (FFS) system. In most cases, beneficiaries remain enrolled in their health plan while receiving these excluded services. Coordination of carved out services is part of the role of the primary care provider. (Refer to Basic Case Management section for more details). Below is a list of those excluded services that may be obtained while a beneficiary remains enrolled in a managed care plan.

Excluded Services

Member remains enrolled in managed care and receives services through the FFS system.

- Acupuncture Services (Two-Plan Model only)
- Healing by Prayer or Spiritual Means Services
- Alcohol and Drug Treatment
- California Children’s Services
- Local Education Agency Services
- Assessment Services
- Chiropractic Services (Two-Plan Model only)
- Dental Services
- Outpatient Heroin Detoxification
- Short-Doyle Medi-Cal Mental Health Services
- Medicaid Home Health Programs
- Directly Observed Therapy for TB

^ There are exceptions for the services noted with a caret. Please see the paragraph titled “Exceptions for Services Not Covered by Molina Healthcare or Regular Medi-Cal.”

Member Disenrolls from Managed Care in Order to Receive Services

- Long-Term Care [approximately sixty (60) days after admission]
- Major Organ Transplantation except Kidney and Cornea

MEDICAL TRANSPORTATION

Member transportation is coordinated through MHC for all members.

Emergency Medical Transportation

Emergency medical transportation is provided when necessary to obtain covered benefits when the member's medical/physical condition is acute and severe, necessitating immediate diagnosis and treatment so as to prevent death or disability.

If a member in a facility has a medical emergency requiring hospitalization, the attending Provider/Practitioner must arrange ambulance transportation by a licensed ambulance company to the nearest emergency room or dial 911 to obtain ambulance service.

Non-Emergency Medical Transportation

MHC provides ambulance, litter van, and wheelchair van medical transportation services. These services are covered only when a member's medical and physical condition is such that ordinary means of public or private transportation would be medically inappropriate. MHC ensures that the transportation coverage is limited to the lowest cost service available that is adequate for the member's needs. Transportation coverage is also limited to the nearest Provider/Practitioner capable of meeting the needs of the member. Providers/Practitioners must contact the Plan's Utilization Management Department in order to obtain authorization. Members are instructed to contact MHC's Member Services Department for authorization and coordination of services, at (888) 665-4621, Monday-Friday 7:00AM-7:00PM. It is recommended that request be made at least seventy-two (72) hours in advance of the service.

Non-Emergency Transportation for Excluded Services

Members or Providers/Practitioners requesting transportation for excluded services should do so through their local Medi-Cal field office. Excluded services are listed above. For additional information on coordination of excluded services, Providers/Practitioners may contact MHC's Case Management Department at (888) 665-4621.

Wheelchair Van

Wheelchair van services for non-emergency medical care are covered when the member's medical and physical condition prohibits the member from sitting in a private vehicle, taxi, or other form of transportation for any length of time, or the member has a disabling physical or mental limitation, or he/she requires specialized safety equipment not found in passenger cars, taxi cabs, or other forms of public transportation. The wheelchair van is covered in the above circumstances only if the member does not require specialized services, equipment, or personnel as provided in an ambulance, i.e. the member is in stable condition and does not require constant observation.

Litter Van

Litter van services for non-emergency medical care are covered when the member's medical and physical condition necessitate that the member be transported lying down for the period of time required for transport, or if the member requires specialized safety equipment not found in passenger cars, taxi cabs, or other forms of public transportation. The litter van is covered in the above circumstances only if the member does not require specialized services, equipment, or personnel as provided in an ambulance, i.e. the member is in stable condition and does not require constant observation.

Ambulance

The use of an ambulance as transportation in non-emergency situations is covered only when the member's medical condition prevents the use of any other form of medical or public transportation, For more information regarding transportation, please contact MHC's Utilization Management Department at (800) 526-8196.

EXCEPTIONS FOR SERVICES NOT COVERED BY MOLINA HEALTHCARE OR REGULAR MEDI-CAL

Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) added Section 14131.10 of the Welfare and Institutions Code (W&I Code) to exclude several optional benefits from coverage under the Medi-Cal Program for members 21 years and older, effective July 1, 2009.

There are a number of exceptions in which Medi-Cal members ages 21 and above will continue to receive optional Medi-Cal benefits when rendered under specific circumstances, in certain places of service or by specific types of providers. This includes the following exceptions:

- Members 21 years of age and older who began a course of treatment before they turned 21 (medically necessary benefits would be covered for such individuals under continuity of care).
- Members undergoing a course of treatment prior to July 1, 2009 that extends past July 1 would continue to receive medically necessary optional benefits until such time as the course of treatment is completed.
- Optional benefits provided by licensed physicians practicing within their scope of practice will remain covered benefits (the same optional benefits provided by non-physicians to non-pregnant adult plan Medi-Cal members will generally not be covered by the plan).
- Pregnancy services.
 - If a woman is pregnant, she may continue to receive pregnancy-related benefits and services. The pregnant member may also receive the optional benefits and services listed above to treat conditions that, if left untreated, might cause difficulties for the pregnancy. This includes dental exams, cleanings, and gum treatment. Dental and other benefits and services may also be available up to sixty (60) days after the baby is born.
- Services provided in hospital outpatient departments and clinics.
- There are no changes to the covered benefits in the Medi-Cal Program for all Medi-Cal members under the age of twenty-one (21).

- There are no changes to the covered benefits for all Medi-Cal members covered by the California Children Services (“CCS”) and Program of All-Inclusive Care for the Elderly (“PACE”) programs.
- There are no changes to the covered benefits in the Medi-Cal Program for all Medi-Cal members residing in a skilled nursing facility (Level A or B; this includes sub-acute care facilities).
- There are no changes to the covered benefits in the Medi-Cal Program for members receiving home health services rendered by a Home Health Agency.

3.1 BENEFITS AND COVERED SERVICES: HEALTH EDUCATION

MOLINA HEALTHCARE HEALTH EDUCATION

Phone: (866) 472-9483 (Monday-Friday 8:30AM-5:30PM) **Fax:** (562) 901-1176

MHC delegates the provision of health education services to IPA affiliated medical groups under the Managed Medi-Cal contract. As Providers/Practitioners, you are in the best position to meet the many educational needs of MHC members at the time of their medical visits. You are the most credible educator for your patients. However, MHC California supports our providers/practitioners by making available many Health Education programs, materials and services that will be discussed below.

DHCS Health Education Contract Requirements for Managed Medi-Cal Members

To meet DHCS Managed Medi-Cal contract requirements for health education services, IPAs/Providers must make available to members educational services in the following areas:

- Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care. Risk–reeducation and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and parenting. Self-care and management of health conditions – pregnancy; asthma; diabetes; and hypertension.

All education must be documented in the member’s medical record. This information should become part of the member’s ongoing medical care as all team members can reinforce new positive health behaviors. This documentation also becomes critical in the event of an audit by any regulatory organization.

Special Programs Provided by Molina Healthcare

To support our provider network, MHC makes available programs and services in many of the required areas. If you are an IPA/Medical Group affiliated Provider/Practitioner, please consult the table titled “Health Education Services” in the exhibit section to determine the remaining requirements that are your responsibility.

Disease Management Programs

MHC accepts referrals to our Disease Management Programs and other services identified as plan priorities. For some of these program areas (i.e. asthma, diabetes, cardiovascular disease and COPD) members are identified by claims data (i.e. hospital admissions, ER visits, and prescribed medications) that MHC collects internally. If a member is identified using these means, the PCP is notified of the member’s enrollment into the program. These programs are open to **all MHC members** without respect to Provider/Practitioner affiliation. These include the following:

- **Breathe with Ease (BWE) Asthma Program** – BWE is a disease management program for members ages 2 and above. Families can receive education telephonically, through the mail, and by referral to group education classes. Participants receive educational materials and other resources to help families manage asthma at home. Case management services are available for children with poorly controlled asthma.
- **Healthy Living with Diabetes Program** – The Healthy Living with Diabetes program is for adult members age 18 and above with a confirmed diagnosis of diabetes. This disease management program is aimed at assisting members with their understanding of diabetes and self-care of the disease. Identified members with diabetes complete an assessment on diabetes and self-care practices. All members identified for specific programs will receive a newsletter. Members are stratified as low, medium, or high risk and receive targeted interventions based upon assessment responses and claims data. Self-monitoring of blood glucose levels is one of the program’s objectives. A meter, test strips, and lancets are a covered benefit under MHC. High risk participants may receive direct telephonic counseling services from a Care Manager. Behavioral action plans are completed and information is sent to you for the coordination of the patient’s medical care.
- **Cardiovascular Disease and Chronic Obstructive Pulmonary Disease** – MHC also offers two additional disease management programs for cardiovascular disease (including hypertension, Ischemic Heart Disease and Congestive Heart Failure) and Chronic Obstructive Pulmonary Disease. These programs are structured the same as the other programs and include significant involvement by Medical Case Management since many of the members identified are at significant health risk for morbid events.

Health Promotion Programs

- **Smoking Cessation Program** – MHC with the CA Smoking Cessation Program to refer members for smoking cessation. When PCPs make a member referral, our health educators contact the member to offer the telephonic counseling program. When members agree, a warm transfer is made to the CA Smoking Cessation Program and the member is enrolled. Member will be provided counseling over the telephone by a quit smoking counselor. PCPs can prescribe nicotine replacement therapy, Zyban or Chantix to use in conjunction with the behavior modification program by faxing a completed Medication Prior Authorization Request Form along with the prescription to (866) 508-6445.
- **Adult Weight Management Program** – MHC offers a popular, effective commercial program to members to address behavior modification strategies needed for weight management (ages 17 and above only). Members are screened for their readiness to make behavior changes before they are referred to this program. Members can also receive educational materials and referrals to other community based programs. Members can continue in the program as long as there is continuous documented weight loss and adequate progression toward an identified goal body weight.

Documentation of interventions conducted is sent back to the PCP for inclusion in the member’s medical record.

Process for Referring a MHC Member to Health Education Services


- Obtain agreement for a referral to Health Education from the member;

- Stress compliance as part of the member’s overall care plan;
- **Refer member for only one condition at a time.** This will help the member not feel overwhelmed;
- Complete the Molina Healthcare Health Education Referral Form. Select the correct referral form (IPA/Medical Group or Direct/SMO) (Available on MHC’s website in the frequently used forms area);
- Fax Health Education Referral Form and supporting documentation to (562) 901-1176;
- Document referral in the member’s medical record;
- Reinforce key concepts and compliance with member at follow-up office visits.

ADDITIONAL HEALTH EDUCATION RESOURCES

Written Patient Education Materials

MHC develops and selects patient education materials that are culturally appropriate for various target populations in key subject areas. The most appropriate setting for a member to receive written literature is from his or her primary care practitioner (PCP) with a brief discussion. MHC recognizes the need for the availability of low literacy health education materials in the member’s preferred languages. MHC offers a variety of low literacy materials available in English, Spanish and other threshold languages. To obtain education materials for your MHC members, please use the appropriate order form. All order forms can be accessed through the MHC website at: www.MolinaHealthcare.com or contact Health Education at (866) 472-9483. All materials are written at the sixth (6th) grade reading level or below to meet lower literacy needs. If a Provider/Practitioner chooses to use their own materials they must be submitted to MHC’s Health Education Department for review and approval for use with Medi-Cal members.

 ***Specific Requirements for Serving Molina Healthcare’s Medi-Cal-only SPD Members***
MHC members with low vision or who are blind should be offered materials in alternate formats including **large print, Braille or audio**. MHC’s contracted providers/practitioners can request materials in alternative formats by contacting the MHC’s Member Services Department.

Health Promotion Campaigns

Posters, brochures, and other promotional materials associated with various health campaigns may be offered to Provider/ Practitioner groups throughout the year. MHC will inform you of upcoming campaigns via “Just the Fax” or mailed letters, providing you information about ordering materials for the campaign.

Health & Family Newsletter

MHC mails an educational newsletter to all members at least twice each year containing a variety of topics suggested by the members and California Department of Health Care Services. A disclaimer is printed on the newsletter informing the member that the contents are for information only and do not take the place of Provider/Practitioner advice. Additional newsletters are also distributed to certain target groups of members (i.e. disease management participants and teens). All newsletters are also made available on the website under Health and Wellness – Newsletters.

Member Wellness Mailings

MHC periodically distributes wellness materials to members. The preventive health guidelines (“Grow and Stay Healthy”) are included in all new member packets and as part of an annual compliance mailing to keep families on track with obtaining recommended physical examinations and tests. Key plan telephone numbers and resources are provided to assist members in using their plan benefits appropriately.



Specific Requirements for Serving Molina Healthcare’s Medi-Cal-only SPD Members
All new seniors and persons with disabilities are sent a Bridge2Access program brochure as part of their new member packets. This brochure highlights services and resources that are important for these members including transportation, Nurse Advice Line, community resources, interpretive services and care management.

Individual Medical Nutrition Therapy (Registered Dietitian “RD” services)

For directly contracted and Molina Medical Group Providers/Practitioners, MHC will provide individual medical nutrition therapy for high-risk conditions with a Provider/Practitioner referral. Complete the Health Education Referral form and indicate risk condition. Attach recent lab results and progress notes to assist the RD in counseling the member most appropriately. All documentation from the appointment with the RD will be sent back to the Provider/Practitioner for inclusion in the member’s medical record.

ADDITIONAL PCP RESPONSIBILITY

Individual Health Education Behavioral Risk Assessment “Staying Healthy”

All Providers/Practitioners of managed Medi-Cal members must administer an individual health education behavioral assessment. This must be done with new patients at their Initial Health Assessment within a 120 days of enrollment into the health plan and with existing members at their next scheduled non-acute care visit (but no later than their next scheduled health screening visit). The DHCS produces “Staying Healthy” Assessment Forms in many age categories. Assessments are to be completed by members 12 years of age and older and by parents of children 11 years of age and younger while waiting for their medical visit. Providers/Practitioners must review the assessment, provide needed counseling or other intervention, document on the assessment, and file in the member’s medical record with other continuity of care forms. This assessment is reviewed with the member or parent at least annually and is re-administered when the member enters the next age category. MHC recommends that the adolescents complete the assessment annually as they change behaviors rapidly during this period.

All completed “Staying Healthy” Assessments for 12-17 year olds should be placed under the “sensitive tab” in the medical record, preventing photocopying should parent/guardian request the record. This precaution protects the confidentiality of the minor’s disclosures. The “Staying Healthy” Assessment forms are available for download on MHC’s website and copies will be made available upon request. Copies can be ordered by completing the order forms posted on the website in the frequently used forms area and faxing back to MHC.

HEALTH PLAN OVERSIGHT (HEALTH EDUCATION AND QUALITY IMPROVEMENT MONITORS IPAS / MEDICAL GROUPS)

Health Education Service Assessment

Upon request by the health plan, all IPAs/Medical Groups must submit the annual Health Education Service Assessment. The assessment must include evidence that all contract required services are being provided to MHC members.

Medical Record Audits and Facility Reviews

Plan initiated medical record audits verify that services are documented in the member’s medical record. Facility reviewers check on availability of health education services and measure compliance with the implementation of the Individual Health Education Behavioral Assessments.

Focused Studies

Quality Improvement executes studies using various indicators. Data from multiple sources may be used, including medical record review, pharmacy utilization, and preventive care utilization.

HEALTH EDUCATION SERVICES

Matrix distinguishing health education service to the IPA affiliated practitioners versus Molina Medical Group (MMG) practitioners or directly contracted practitioners.

Program/Service labeled “X” are MHC programs/services that are available to both MMG directly contracted practitioners and IPA affiliated Practitioners.

HEALTH EDUCATION SERVICES	MMG/DIRECTLY CONTRACTED PRACTITIONERS	IPA-AFFILIATED PRACTITIONERS
Smoking Cessation Program	X	X
Breathe With Ease Pediatric Asthma Program (2-56 years old) *	X	X
Healthy Living with Diabetes Program (18-75 years old) *	X	X
Motherhood Matters Pregnancy Program *	X	X
Healthy Baby Program (child safety education and car seat up to 18 months old) *	X	X
Member materials (brochures, fact sheets, etc., practitioners can give to MHC members during the office visit)	X	X
All “Staying Healthy” Assessment resources needed for implementation (forms, patient education tip sheets, office training video, and provider handbook)	X	X

HEALTH EDUCATION SERVICES	MMG/DIRECTLY CONTRACTED PRACTITIONERS	IPA-AFFILIATED PRACTITIONERS
Community program referrals	X	X
Weight Management Program (17 years old and above)	X	X
Pediatric Weight Management	X	IPA Responsibility
Education for any of the following: cholesterol, hypertension, STD/HIV prevention, family planning, injury prevention, nutrition, or physical activity	X	IPA Responsibility
Referrals for MHC member identified as needing Medical Nutrition Therapy for a specific health condition	X	IPA Responsibility

* These programs are not available to LA County members, but may be offered by their primary contracted health plans.

Please note: MHC also mails health education materials to its members on request and as scheduled disease management interventions. *The Health and Family newsletter* is produced and mailed at least twice each year.

3.2 BENEFITS AND COVERED SERVICES: CULTURAL AND LINGUISTIC SERVICES

Title VI of the Civil Rights Act, *the Americans with Disabilities Act (ADA)* and *Section 504 of the Rehabilitation Act of 1973* and other regulatory / contract requirements ensure that limited English proficient (LEP) individuals and *members who are deaf, hard of hearing or have speech or cognitive / intellectual impairments* have equal access to health care services through the provision of high quality cultural and linguistic services. MHC provides a number of important cultural and linguistic services at no cost to assist members and Providers/Practitioners.

The California Department of Health Care Services (DHCS) and MHC and its affiliates expect Providers/Practitioners to adhere to the following:

24 Hour Access to Interpreters

Providers/Practitioners may request interpreters for members whose primary language is other than English by calling MHC's Member Services Department at (888) 665-4621. If Member Services representatives are unable to provide the interpretation services internally, the member and Provider/Practitioner are then connected to a telephonic language line interpreter service. TTY/TTD services are available for *deaf and hard of hearing members by calling the California Relay Service at 711.*

It is never permissible to ask a family member, friend or minor to interpret. State and Federal laws state that it is never permissible to turn a member away or limit the services provided to them because of language barriers. It is also never permitted to subject a member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English.

Face to Face Interpretation

Providers/Practitioners may request face to face interpretation (*including Sign Language*) for scheduled medical visits, if needed, due to the complexity of information exchange or if requested by the member. To request face to face interpretation services call our Member Services Department at (888) 665-4621, fax in requests to (562) 901-9632, or e-mail MHC-Interpreters@MolinaHealthcare.com. Our Member Services Representatives will arrange for an interpreter. Please keep in mind that we recommend at least three (3) business days to make arrangements for this service. Sign language interpreters are in high demand and may require at least five (5) business day notice.

Face to face interpretation is desirable for certain complex medical situations such as the need to give complex instructions (i.e. such as how to inject insulin, or postsurgical care), the discussion of health issues requiring major lifestyle changes, the discussion of a terminal prognosis, or other critical healthcare issues. Interpreter services should be provided if a member believes that his or her rights to equal access to medical care, under Title VI *or the ADA*, will not be met without the services of a face to face interpreter.

Member Interpreter Request Card

All new non-English speaking MHC members are provided an Interpreter Request Card which they can keep in their wallet. On the front side of the card it states that they are a MHC member and that they are requesting an interpreter. The other side is written in Spanish, Vietnamese, Chinese, Hmong, Arabic, or Russian and explains to the member how to use the card.

Interpreter Request Cards are also available for deaf and hard of hearing members who need a Sign Language Interpreter.

Nurse Advice Line

MHC provides twenty-four (24) hours/seven (7) days a week nurse advice services for members. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call MHC's Nurse Advice Line directly [English line (888) 275-8750] or [Spanish line at (866) 648-3537] or for assistance in other languages. *The Nurse Advice TTY is (866) 735-2929.* The Nurse Advice Line telephone numbers are also printed on membership cards.

Assistive Listening Devices

MHC strongly recommends that provider offices make available assistive listening devices for members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider/practitioner's voice to facilitate a better interaction with the member.

Documentation

As a contracted MHC provider, your responsibilities for documenting member language services/needs are as follows:

- Record the member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by MHC.
- All requests for interpreter services by members must be documented in the Member's medical record.
- Providers/Practitioners should document who provided the interpretation service. That information could be the name of internal staff or someone from a commercial vendor.
- Offer your MHC members interpreter services if they do not request them on their own.
- It is never permissible to ask a family member, friend or minor to interpret. If a member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost, document this in the member's medical record.
- All counseling and treatment done via interpreter should be noted in the medical record by stating that such counseling and treatment was done by utilizing interpretive services.

Facility Signage

DHCS requires that Provider/Practitioner offices post important signs in the threshold languages for the area. The current threshold languages are as follows:

Los Angeles County	Sacramento County	Riverside County	San Bernardino County	San Diego County
English	English	English	English	English
Spanish	Hmong	Spanish	Spanish	Spanish
Armenian	Russian			Vietnamese
Vietnamese	Spanish			Arabic
Khmer (Cambodian)	Vietnamese			
Chinese	Chinese			
Russian				
Korean				
Farsi				
Tagalog				

To receive updates on this requirement, or if you need particular signage and cannot locate it, call the Cultural & Linguistic (C & L) Specialist for help.

Consultation and Training on Cultural/Linguistic Issues

Providers/Practitioners may call the C & L Specialist for a consultation on a compliance issue that may be culturally or linguistically related. Additionally, the C & L Specialist is available to conduct training sessions for IPA/Medical Group sponsored meetings. MHC's C & L Specialist may be contacted at (800) 526-8196 ext. 127421.

Ask the Cultural and Linguistics Specialist

This is an interactive web based question and answer forum on MHC's website for providers. This format allows MHC contracted physicians with Internet access to pose questions related to providing culturally appropriate care. All inquiries receive a response within 72 hours from MHC's Cultural and Linguistic Specialist. To access, go to: http://MolinaHealthcare.com/medicaid/providers/ca/resource/ask_cultural.html

Referrals to Multi-Ethnic Community-Based Services

Community resource lists may be obtained from the Health Education Department. Practitioners may call the Health Education Department at (800) 526-8196, ext. 127421, 8:30 a.m. to 5:30 p.m., Monday through Friday, to get the most recent information about services for a particular community. In addition, the C & L Specialist can help you find services and resources for some of the smaller and more unique communities.

Community Advisory Committees

MHC coordinates important Community Advisory Committees (CAC) that serve to guide MHC in addressing issues of culture and language as they relate to the Plan's delivery of quality care. These committees include a wide range of public and private health care Providers/Practitioners and representatives of community based organizations. MHC maintains active Community Advisory Committees in San Diego, Riverside, and San Bernardino, and supports the all health plan Community Advisory Committee in the Sacramento area. If you are interested in participating, call the C & L Specialist.

4.0 QUALITY IMPROVEMENT: ACCESSIBILITY OF SERVICES

ACCESSIBILITY TO CARE STANDARDS

Molina Healthcare of California is committed to timely access to care for all members. The Access to Care Standards below are to be observed by all Providers/Practitioners.

Appointments with the Primary Care Practitioner (PCP)

Members are instructed through their member handbook to call their PCP to schedule appointments for routine/non-urgent care, preventive care and urgent/emergency care visits. The PCP is expected to ensure timely access to MHC members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the scope of the PCP's practice.

Standards of Accessibility

Access standards have been developed to ensure that all health care services are provided in a timely manner, however, the waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health care professional providing triage or screening services, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and documented in the relevant patient medical record that a longer waiting time will not have a detrimental impact on the health of enrollee.

These standards are based on regulatory and accreditation standards. MHC monitors compliance to these standards. Appointment and other office standards are listed below:

Type of Care and Service	Molina Healthcare Standards
Emergency Care	Immediately
Urgent Care Appointments	Within 24 hours of the request
Urgent Care Appointments with a Specialist	Within 24 hours of the request
Routine or Non-Urgent Care Appointments	Within 4 working days of the request
Routine or Non-Urgent Care Appointments with a Specialist	Within 10 working days of the request
Routine or Non-Urgent Care Appointment with a Non-Physician Mental Health Provider	Within 10 working days of the request
Routine or Non-Urgent Care Appointment for Ancillary Services	Within 15 working days of the request
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within 7 working days of the request

Type of Care and Service	Molina Healthcare Standards
Adult Preventive Care Appointments	Within 20 working days of the request
Initial Health Assessment for a New Members (under 18 months of age)	Within 120 days of the enrollment
Initial Health Assessment for a New Members (over 18 months of age)	Within 120 days of the enrollment
Maternity Care Appointments for First Prenatal Care	Within 5 working days of the request
Office Telephone Answer Time (during office hours)	Within 45 seconds of call
Office Response Time for Returning Member Calls (during office hours)	Within same working day of call
Office Wait Time to be Seen by Physician (for a scheduled appointment)	Should not exceed 30 minutes from the appointment time
After-Hour Instruction for Life-Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911."
Physician Response Time to After-Hour Phone Message, Calls and/or Pages	Within 30 minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for members.

After Hours Care and Emergencies

The PCP or his/her designee must be available twenty four (24) hours a day, seven (7) days a week. MHC requires a Provider/Practitioner or a registered nurse under his/her supervision to maintain a twenty four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The answering service or recorded message should instruct members with a life-threatening emergency to hang-up and call 911 or go immediately to the nearest emergency room. After-hour answering service or recorded message must provide a clear instruction on how to reach the physician or the designee (on-call physician) during after business hours. Physician or the designee must respond to urgent after-hours phone calls, messages, and/or pages within thirty (30) minutes.

Primary Care Office Hours

Generally office hours are from 9:00 a.m. to 5:00 p.m. However, the Provider/Practitioner has flexibility to maintain his/her own reasonable and regular office hours. All primary care sites are required to post their regular office hours and be available to the members at least twenty (20) hours a week at the site. Answer time for a live person in the office to converse with a member caller is within forty-five (45) seconds of the call during office hours. Response time for returning member calls during office hours is within the same business day of the call. Office wait time to be seen by the physician for a scheduled appointment should not exceed thirty (30) minutes from the appointment time.

Urgent and Emergency Care at the Primary Care Practitioner's Office

The facility must have procedures in place to enable access to emergency services twenty four (24) hours a day, seven (7) days a week. The facility staff needs to be knowledgeable about

emergency procedures and be capable of coordinating emergency services. The recommended equipment for required emergency procedures needs to be easily accessible.

The emergency inventory list needs to be posted with drug expiration dates. Examples of emergency drugs are epinephrine and Benadryl. Oxygen needs to be secured, full, and equipped with a flow meter. The mask and Cannula need to be attached. Oral airways and ambu bags appropriate for patient population need to be available. (*Refer to DHCS Facility checklist, Physician Facility Reviews*). If there is need for Basic Life Support or Emergency Medical Services (EMS), dial 911.

Facility Physical Access for the Disabled

MHC ensures that participating PCPs provide physical access for disabled members comply with the Americans with Disabilities Act (ADA) of 1990. Physical access should include availability of ramps, elevators, modified restrooms, designated parking spaces close to the facility, and drinking water provisions. If any physical barriers to disabled accessibility exist, MHC will discuss potential resolution with the Provider/Practitioner or the contracted IPA/Medical Group. Access for the disabled is assessed during the PCP facility site review or Specialist physical access audit conducted by MHC.

Monitoring Accessibility of Services for Compliance with Standards

MHC monitors compliance with the established standards above. MHC contracts with an independent vendor to conduct a telephone appointment and after-hour availability survey annually to determine if the Provider/Practitioners' offices meet the service accessibility standards. A statistically valid random sample of MHC's contracted Provider/Practitioner's offices is selected for the survey. One or all of the following appointment scenarios maybe addressed: routine/non-urgent care; urgent care; preventive care (adults and children); and afterhours information and availability. The results of the survey are distributed to the Providers/Practitioners after its completion.

TIMELY ACCESS TO CARE: SENSITIVE AND CONFIDENTIAL SERVICES FOR ADOLESCENTS AND ADULTS

Sensitive Services means those services related to:

- Sexual Assault
- Drug or alcohol abuse for children 12 years of age or older
- Pregnancy
- Family Planning
- Sexually transmitted diseases for children 12 years of age or older
- Abortion services
- HIV testing/counseling

The following is a brief guide on providing access to members for these sensitive areas.

Timely Access to Services and Treatment Consent

Members under the age of 12 years require parental or guardian consent for obtaining services in the areas of sexually transmitted diseases or drug/alcohol abuse. Minors under the age of 12 years

seeking abortion services are subject to state and federal law. Those age 12 and over can obtain any and all of the above services by signing the Authorization for Treatment form. Timely access is required by Providers/Practitioners for members seeking the sensitive/confidential medical services for family planning and/or sexually transmitted diseases, HIV testing/counseling, as well as for confidential referrals for treatment of drug and/or alcohol abuse.

Family Planning Services

To enhance coordination of care, PCPs are encouraged to refer members to MHC Providers/Practitioners for family planning. Members, however, do not require prior authorization from their PCP to seek family planning services. This freedom of choice provision is the result of federal legislation.

Privacy and Security of Protected Health Information

Member and patient Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. In addition, Providers/Practitioners must implement and maintain appropriate administrative, physical, and technical safeguards to protect the confidentiality of medical records and other PHI. Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. In general, most California healthcare Providers/Practitioners are subject to the following laws and regulations pertaining to privacy of health information:

- Federal Laws and Regulations
 - HIPAA
 - Medicare and Medicaid laws
- California Laws and Regulations
 - Confidentiality of Medical Information Act (COMIA)
 - Patient Access to Health Records Act (PAHRA)

Measurement of Clinical and Service Quality

Molina Medicare monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS[®])
- Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])
- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

1. Healthcare Effectiveness Data and Information Set (HEDIS[®]) - MHC utilizes the NCQA[®] HEDIS[®] as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS[®] is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS[®] measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, glaucoma screening, medication use and cardiovascular disease. HEDIS[®] results are used in a

variety of ways. They are the measurement standard for many of MHC's clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs. Selected HEDIS[®] results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

2. Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) - CAHPS[®] is the tool used by Molina Medicare to summarize member satisfaction with the health care and service they receive. CAHPS[®] examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS[®] survey is administered annually in the spring to randomly selected Members by a NCQA certified vendor. CAHPS[®] results are used in much the same way as HEDIS[®] results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina Medicare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

3. Provider Satisfaction Survey - Recognizing that HEDIS[®] and CAHPS[®] both focus on member experience with healthcare providers and health plans, MHC conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Medicare, as this is one of the primary methods used to identify improvement areas pertaining to the MHC Provider Network. The survey results have helped establish improvement activities relating to Molina Medicare's specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

4. Effectiveness of Quality Improvement Initiatives - MHC monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels (HEDIS and Practice Guidelines). The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods. Contracted Providers and Facilities must allow MHC to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

Benefits and Services

The PCP should encourage members to seek family planning services from Providers/Practitioners within MHC. This process will help to coordinate care and maintain continuity, supporting better health outcomes. Members have the right to access family planning services in a timely manner without need of prior authorization. Members need to access medical care based on the nature of their medical problem. Members may request a referral for drug and/or alcohol treatment programs. Please refer to Healthcare Services Section: Additional Services or Carve-out Services for further details and a list of benefits of the drug and alcohol

program. Members will receive obstetrical services according to the Pregnancy and Maternal Care policy found in Compliance Section: Women's and Adult Health Services, Including Preventive Care. Members may receive family planning services from in plan or out of plan Providers/Practitioners as outlined in Compliance Section.

EMERGENCY CARE

Emergency Care

Emergency Services means those services needed to evaluate or stabilize an Emergency Medical Condition. Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- 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 to bodily functions, or
- Serious dysfunction of any bodily organ or part

Emergency services using the prudent layperson definition or that meet Title 22 criteria for an emergency, do not require MHC prior authorization. In accordance with California Department of Health Care Services' policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and MHC will pay the Medical Screening Exam fee. Emergency room staff is required to notify MHC at the following number of a member's emergency room visit: **(888) 275-8750 (Molina Healthcare 24/7 Nurse Advice Line)**

Notification Requirements

Any emergency service resulting in an inpatient admission requires MHC notification and authorization within 24 hours (or the next business day) of the admission. Furthermore, "Out of Area" and/or non-contracted emergency service Providers/Practitioners are required to notify MHC when the member's condition is deemed stable for follow up care in MHC's service area and at a contracted facility. MHC adheres to the regulations set forth in Title 28, California Code of Regulations, Chapter 3, Section 1300.71.4, Emergency Medical Condition and Post Stabilization Responsibilities for Medically Necessary Health Care Services.

Phone: (800) 526-8196, ext. 126410 or Fax: (866) 472-6303

Emergency Room Discharge and After-Care

Aftercare instructions should be documented in the emergency facility medical record and communicated to the patient, parent, or guardian. Discharge from the emergency facility is performed on the order of a Provider/Practitioner.

Urgent Care

Direct and Molina Medical Group's Contracted Urgent Care Providers/Practitioners may obtain authorization for *urgent care* services by contacting the MHC Utilization Management Department. Telephone assistance for members and Providers/Practitioners is available twenty four (24) hours a day, seven (7) days a week through MHC's Nurse Advice Program.

NURSE ADVICE PROGRAM

MHC provides twenty four (24) hour Nurse Advice access for members and Providers/Practitioners. Licensed Registered Nurses perform telephone assessment of the member's complaints, provide telephone triage utilizing standardized guidelines which are reviewed and approved by the Nurse Advice Medical Director, and provide advice within the scope of their Registered Nurse license. Only licensed Registered Nurses offer advice regarding the member's medical condition and make referrals to appropriate level of care for treatment in accordance with established standards of practice. MHC Nurse Advice does not employ or allow Licensed Vocational Nurses to provide telephone triage/advice.

The goals of the Nurse Advice program are to:

- Advise and refer members to appropriate level of care in a timely manner
- Coordinate the member's care with the PCP
- Notify participating IPAs/Medical Groups of member's ER visit and need for future care
- Educate members on health issues
- Assist in identifying members who might benefit from additional case management services from MHC.

The Nurse Advice programs are available to members and Providers/Practitioners twenty four (24) hour a day by calling: **(888) 275-8750 English** **(866) 648-3537 Spanish**

A tracking mechanism overseen by MHC is in place to follow up on the disposition of the member as indicated, i.e. inpatient admission, urgent care or emergency care level treatment, need for specialty care, and office follow-up. This system is also responsible for ensuring notification to the PCP or IPA/Medical Group regarding members in need of follow-up care.

5.0 MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER BENEFITS

Health care professionals contracted with the State of California's Medi-Cal Program are obligated to provide member services in accordance with standards as to frequency, access, and medical office policies and procedures. The following gives a brief overview of these obligations.

Physicians from the following categories are eligible to be a Primary Care Physician (PCP); Family Practice, General Practice, Internal Medicine, OB/GYN, and Pediatricians. PCPs may self-restrict their practice by age or sex, or Molina Healthcare of California (MHC) may restrict member assignment to a PCP by age or sex (e.g., OB/GYN may be restricted to adult women, Pediatricians to children and adolescents).

PCPs must be able to provide the full range of preventative and acute health care and Comprehensive Medical Case Management services for all members assigned to them.

PCP Scope of Services Requirements

PCPs are required to provide the following services to members assigned to them:

- Detect, diagnose, and effectively manage common symptoms and physical signs.
- Treat and manage common acute and chronic medical conditions.
- Perform ambulatory diagnostic and treatment procedures (injections, aspirations, splints, minor suturing, etc.).
- An Initial Health Assessment (IHA) within 120 days of enrollment which consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered by the Molina Medi-Cal managed care benefit (e.g. carved out and linked services).
- Foster health promotion and disease prevention (age specific screening, health assessment and health maintenance activities, health education and promotion, including healthy lifestyle changes, etc.).
- Provide Comprehensive Medical Case Management (refer to community resources and available supplemental programs, coordinate care with specialists, etc.). Refer to specialists, other providers and facilities appropriately to member care needs.
- Follow required procedures for specialist, diagnostic, or service referral as promulgated by IPA/Medical Group and/or MHC.



Specific Requirements for Serving Molina Healthcare's Medi-Cal-only SPD Members

Follow coordination of care instructions as described in the Utilization Management section of this Manual (CONTINUITY OF MEMBER CARE).

MOLINA HEALTHCARE MEMBER RIGHTS AND RESPONSIBILITIES

This document explains the rights of MHC's Medi-Cal members, as stated verbatim as in the Member's Evidence of Coverage (EOC) Guide. Providers/Practitioners and their office staff are encouraged to be familiar with this document, post it in their office (poster provided by MHC), and are expected to abide by these rights. MHC's member rights and responsibilities are as follows:

What are My Rights and Responsibilities as a Molina Healthcare Member?

These rights and responsibilities are posted in doctors' offices and on the Molina Healthcare website: www.MolinaHealthcare.com.

Member Rights

- Members have the right to be treated with respect and recognition of their dignity by everyone who works with MHC.
- Members have the right to get information about MHC, our providers, our doctors, our services and member's rights and responsibilities.
- Members have the right to choose their "main" doctor MHC's network (This doctor is called a primary care doctor or personal doctor).
- Members have the right to be informed about their health. If they have an illness, members have the right to be told about all treatment options regardless of cost or benefit coverage. Members have the right to have all their questions about their health answered.
- Members have the right to help make decisions about their health care. Members have the right to refuse medical treatment.
- Members have the right to privacy. MHC keeps their medical records private subject to State and Federal laws.
- Members have the right to see their medical record, including the results of their Initial Health Assessment (IHA).
- Members also have the right to get a copy of and correct their medical record where legally ok, subject to State and Federal laws.
- Members have the right to complain about MHC or their care. Members can call, fax, email or write to MHC Member Services.
- Members have the right to appeal MHC's decisions.
- Members have the right to have someone speak for them during their grievance.
- Members have the right to disenroll from MHC. (Leave the MHC Health Plan)
- Members have the right to ask for a second opinion about their health condition.
- Members have the right to ask for someone outside MHC to look into therapies that are experimental or being done as part of exploration.
- Members have the right to decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- Members have the right to get interpreter services on a 24 hour basis at no cost to help them talk with their doctor or us if they prefer to speak a language other than English.
- Members have the right to not be asked to bring a minor, friend, or family member with them to act as their interpreter.
- Members have the right to get information about MHC, their providers, or their health in the language they prefer.

- Members also have the right to ask for and get materials in other formats such as larger size print, audio, and Braille upon request and in a timely fashion appropriate for the format being requested in accordance with state laws.
- Members have the right to get a copy of MHC's list of approved drugs (drug formulary) on request.
- Members have the right to submit a grievance if they do not get medically needed medications after an emergency visit at one of MHC's contracted hospitals.
- Members have the right to get minor consent services.
- Members have the right not to be treated poorly by MHC, their doctors or the Department of Health Care Services for acting on any of these rights.
- Members have a right to make recommendations regarding the organization's member rights and responsibilities policies.
- Members have the right to be free from controls or isolation used to pressure, punish or seek revenge.
- Members have the right to file a grievance or complaint if they believe their linguistic needs were not met by MHC.
- Medi-Cal Members also have the right to receive instructions on how they can view online, or request a copy of, MHC's non-proprietary clinical and administrative policies and procedures.
- Medi-Cal Members also have the right to ask for a State Fair Hearing by calling toll-free (800) 952-5253. Members also have the right to get information on how to get an expedited State Fair Hearing quickly.
- Medi-Cal Members also have the right to have access to family planning services, Federally Qualified Health Centers, Indian Health Services Facilities, sexually transmitted disease services, and Emergency services outside of MHC's network according to federal laws. Members do not need to get MHC's approval first.

Member Responsibilities

- Members have the responsibility to learn and ask questions about their health benefits. If Members have a question about their benefits, call toll-free at 1-888-665-4621.
- Members have the responsibility to give information to their doctor, provider, or MHC that is needed to care for them.
- Members have the responsibility to be active in decisions about their health care.
- Members have the responsibility to follow the care plans that they have agreed on with their doctor(s).
- Members have the responsibility to build and keep a strong patient-doctor relationship, cooperate with their doctor and staff, keep appointments, and be on time. If Members are going to be late or cannot keep their appointment, they have the responsibility to call their doctor's office.
- Members have the responsibility to give their MHC and State card when getting medical care, not give their card to others, and to let MHC or the State know about fraud or wrong doing.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals as they are able.

Be Active In Your Healthcare Plan Ahead:

- Members should schedule their appointments at a good time for them
- Members should ask for their appointments at a time when the office is least busy if they are worried about waiting too long
- Members should keep a list of questions they want to ask their doctor
- Members should refill their prescription before you run out of medicine

Make the Most of a Doctor Visit

- Members should ask their doctor questions
- Members should ask about possible side effects of any medication prescribed
- Members should tell their doctor if you are drinking any teas or taking herbs
- Members should also tell their doctor about any vitamins or over-the-counter medications they are using
- Members should visit their doctor when they are sick. Members should try to give their doctor as much information as they can.
- Members should tell their doctors if they are getting worse or if their symptoms staying about the same
- Members should tell their doctors of they have you taken anything

If members would like more information, please instruct them to call MHC's Member Services Department at (888) 665-4621, Monday through Friday, between 7:00am and 7:00pm.

MEMBER CONFIDENTIALITY

According to MHC's Medi-Cal Member Rights, members have the right to full consideration of their privacy concerning their medical care program. They are also entitled to confidential treatment of member communications and records.

Case discussion, consultation, examination, Medi-Cal eligibility, and treatments are confidential and should be conducted with discretion. Member Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and the California Civil Code.

Office Procedure

All participating Providers/Practitioners must implement and maintain office procedures that will guard against disclosure of any PHI to unauthorized persons. These procedures should include at least the following elements:

- Written authorization obtained from the member or his/her legal representative, before medical records or other PHI is disclosed to a third party for a purpose not otherwise permitted or required under applicable federal or state laws.

- All signed authorizations for the use or disclosure of PHI must be carefully reviewed to verify that the authorization is valid and meets the requirements of applicable federal and state law.
- Each medical record and other PHI should be reviewed prior to making it available to anyone other than the member or legal personal representative of the member.
- Only the portion of the medical record and other PHI specified in the authorization should be made available to the requester and should be separated from the remainder of the member's medical records.

Confidential Information

Confidential information also refers to any identifiable information about a member's character, conduct, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. More than the medical record constitutes, conversations, whether in a formal or informal setting, email, faxes, and letters are other potential sources of confidential member information.

Member confidentiality must be maintained at all times when providing health care services and during claims processing.

HIPAA Security & Submitting PHI/Medical Records to MHC

Providers are expected to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity and medical theft is a rapidly growing problem in the healthcare industry and that patients trust their healthcare providers to keep their most sensitive information private and confidential.

As part of PHI Safeguards, it is also imperative for providers to submit claims or medical records to appropriate mailboxes identified for each applicable line of business. MHC Providers/Practitioners are encouraged to submit claims and other transactions to MHC using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following: Claims and encounters, Member eligibility status inquiries and responses, Claims status inquiries and responses, Authorization requests and responses, and Remittance advices. MHC is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to MHC's website at: www.MolinaHealthcare.com for additional information. Click on the link "For Health Care Professionals", select a state, click the tab titled "HIPAA."

Furthermore, please be advised that submission of "unencrypted" CDs with medical record information or hard copy medical records to incorrect mailboxes are unacceptable. Should medical records need to be sent via hard copies to MHC, MHC highly recommends that the records be sent via certified mail. Please also note the below appropriate addresses to submit various claims documents for prompt processing. **Please use the P.O. Boxes provided below** for timely submission of your claims, corrected claims and medical records (applicable claim must be attached), PM 160s and encounter data.

If you have any questions or require further clarification regarding this notification, please contact your regional Provider Services Representatives.

MEMBER SATISFACTION SURVEY

MHC, or the State of California, conducts an annual satisfaction survey of its Medi-Cal members. The National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plans Survey (CAHPS) is conducted annually. NCQA translates the survey into English and Spanish only. It is not available in other languages. MRMIB (Managed Risk Medical Insurance Board) conducts an annual survey similar to CAHPS.

The purpose of the surveys is to gather information from members regarding their perception of the health plan, their health care, Providers/Practitioners, access to care, and health plan customer service. The data is used to identify systemic issues that need to be addressed. The annual survey results are communicated in the MHC physician newsletter.

The survey can be viewed on the NCQA.org web site.

6.0 APPEALS AND GRIEVANCES/COMPLAINTS

GRIEVANCES AND APPEALS

What to do if you receive a:

- Pre-service or prior authorization denial for lack of information: Resubmit the request to UM with the UM requested additional information
- Pre-service or prior authorization denial for lack of medical necessity, failure to meet criteria, or non-benefit: Appeal on behalf of the member by contacting the MHC Member Services Department at (888) 665-4621
- Post-service or retrospective authorization denial: Appeal on behalf of the member by contacting the MHC Member Services Department at (888) 665-4621
- Payment denial for any reason except for an unclean claim: Appeal your payment denial within three hundred sixty five (365) days using the dispute resolution process
- Non-payment for an unclean claims: Submit a clean claim within the noted timeframe and with the information that is requested in the remit message

Grievances and Appeals

This section addresses the identification, review, and resolution process for four (4) distinct topics:

- Provider/Practitioner Appeal (related to an authorization determination)
- Provider Disputes-Title 28, CCR, Section 1300.71.38 (related to provider claims appeals)
- Member Appeals (related to an authorization determination)
- Member Grievance [related to a Potential Quality of Care (PQOC) issue]

More information regarding PQOCs may be obtained by contacting MHC's Quality Improvement Department at (800) 526-8196, ext. 126137.

PROVIDER/PRACTITIONER GRIEVANCES OR COMPLAINTS - THE "APPEALS PROCESS"

A Provider/Practitioner grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. MHC maintains two types of appeals:

- Appeals regarding non-payment or processing of claims known as Provider Disputes.
 - A Provider/Practitioner of medical services may submit to MHC an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a claim by the Plan. MHC will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and Title 28, CCR, Section 1300.71 and 1300.38 Claims Settlement Practices and Provider Dispute Resolution.
- Appeals regarding modifications or denial of a service request.
 - The Provider/Practitioner Appeal Process offers recourse for Providers/Practitioners who are dissatisfied with a denial or decision from MHC.

There are two (2) types of appeals-Provider Disputes and appeals for prior authorization denied. The initial appeal is considered to be a First Level appeal, and if the disputed denial is upheld during the First Level appeal, a final or Second Level appeal may be requested.

PROVIDER DISPUTES

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested
- Challenges MHC's request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service in 2004 or after, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the provider. For paper submission, MHC will acknowledge the receipt of the dispute within fifteen (15) working days and within two (2) days for electronic submissions. If additional information is needed from the provider, MHC has forty five (45) working days to request necessary additional information. Once notified in writing, the provider has thirty (30) working days to submit additional information or the claim dispute will be closed by MHC.

Providers may initiate a first level appeal by submitting and completing a Provider Dispute Resolution Request Form within three hundred sixty five (365) days from the last date of action on the issue. The written dispute form must include the provider name, identification number, contact information, date of service, claim number, and explanation for the dispute. In addition, the following documentation is required to review and process a claims appeal:

- Provider Dispute Resolution Request Form or a Letter of Explanation
- A copy of the original claim(s)
- A copy of the disposition of original claim(s) in the form of the Explanation of Benefit
- Documented reason for appeal
- A copy of the medical record/progress notes to support the appeal, when applicable

Provider Disputes and supporting documentation (via paper) should be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Grievance and Appeals Unit

Appeals Involving Shared Risk Capitated IPAs/Medical Groups

If an appeal involves a member who is assigned to a Primary Care Practitioner (PCP) or IPA/Medical Group under a shared-risk capitated compensation agreement, MHC will delegate the first level of appeal to the IPA/Medical Group. MHC does not delegate the second level appeals heard by the Health plan. However, MHC will make the final determination on all appeals received from Providers/Practitioners. All first appeals should be mailed directly to the participating IPA/Medical Group. All first appeals received by MHC will be forwarded to the IPA/Medical Group upon receipt. The IPA/Medical Group will review the appeal and make an initial determination within fifteen (15) days of receipt of the appeal.

If the decision is to overturn the original denial, the IPA/Medical Group will respond to the Provider/ Practitioner and pay the claim. If the determination is to continue to uphold the denial, the IPA/Medical Group will then forward the first level appeal to MHC or its affiliated health plan (Attention: Utilization Management Department) for a second level appeal determination. If MHC upholds the denial, the Provider/Practitioner will be notified of the second level appeal decision at that time.

Appeals Involving Direct Providers/Practitioners

If an appeal involves services that were provided to a member who is assigned to a Direct PCP, MHC will administer the Provider/Practitioner appeals process.

Appeals Address

Claims for plan or shared-risk services must be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Grievance and Appeals Unit

Balance Billing

MHC prohibits Providers/Practitioners from balance-billing a member when the denial disputed in a First Level or Second Level appeal is upheld. The Provider/Practitioner is expected to adjust off the balance owed if the denial is upheld in the appeals process.

MEMBER APPEALS

A Provider/Practitioner on behalf of a member may appeal a Utilization Management decision to deny or modify a requested service.

Member Appeals Process

If the Member or Provider/Practitioner on behalf of a member is dissatisfied with an adverse authorization decision, he or she may initiate an appeal by telephone, fax, in writing, or on MHC's website. Providers/Practitioners may refer members to MHC's website for additional information on how to file a member grievance. Contact the department noted below, Monday-Friday between 7:00 am and 7:00 pm:

Molina Healthcare of California
Attn: Member Grievance and Appeals Unit
200 Oceangate, Suite 100
Long Beach, CA 90802
(888) 665-4621
Fax: (562) 901-9632
www.MolinaHealthcare.com

Standard (30-day) and Expedited (72-hour) Appeal Processes

Health plans have thirty (30) days to process a standard appeal. In some cases, members have the right to an expedited, seventy two (72) hour appeal. Members can get a faster, expedited appeal if the member's health or ability to function could be seriously harmed by waiting for a standard appeal. If a member requests an expedited appeal, the health plan will evaluate the member's request and medical condition to determine if the appeal qualifies as an expedited, seventy two (72) hour appeal. If not, the appeal will be processed within the standard thirty (30) days.

**(The following sections indicated with an asterisk were extracted verbatim from the Medi-Cal Program Evidence of Coverage Guide for Providers/Practitioners to understand Independent Medical Review as explained to the members.)*

***Independent Medical Review**

You may request an independent medical review (IMR) of a disputed healthcare service from the Department of Managed Health Care (DMHC) if you believe that healthcare services have been improperly denied, modified, or delayed by MHC or one of its contracted providers. A "disputed healthcare service" is any healthcare service eligible for coverage and payment that has been denied, modified, or delayed by MHC or one of its contracted providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. MHC will provide you with an IMR application form with any disposition letter that denies, modifies, or delays healthcare services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against MHC regarding the disputed health care service.

Eligibility: Your application for an IMR will be reviewed by the DMHC to confirm that:

1.
 - A. Your provider has recommended a healthcare service medically necessary, or
 - B. You have received urgent care or emergency services that a provider determined was medically necessary, or
 - C. You have been seen by a Plan Provider for the diagnosis or treatment of the medical condition for which you seek medical review;
2. The disputed healthcare service has been denied, modified, or delayed by MHC or one of its contracting providers, based in whole or in part on a decision that the healthcare service is not medically necessary: and
3. You have filed a grievance with MHC or its contracting provider and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow MHC's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will get a copy of the assessment made in your case. If the IMR determines the service is medically necessary, MHC will provide the healthcare service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call MHC at (888) 665-4621.

***Expedited State Fair Hearing**

You or your provider may request an Expedited State Hearing by calling, writing or faxing:
Department of Health Care Services
Expedited Hearing Unit
744 P Street, MS 1965
Sacramento, CA 95814
Fax: (916) 229-4267

MHC or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function. When Expedited Hearing Unit determines that your appeal satisfies the expedited criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Fair Hearing as described above.

***Department of Managed Healthcare Services (DMHC) Assistance**

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at (888) 665-4621 and use your health plan's grievance before contacting the department. 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 thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll free telephone number (888-HMO-2219) and a TTD line (877-688-9891) for the hearing and speech impaired. The department's Internet website <http://www.hmohelp.ca.gov> has complaint forms, IMR applications forms and instructions online.

***State Fair Hearing**

In addition to the grievance processes offered by MHC, you have the right to request a Fair Hearing from the State of California at any time during the process. You have a right to request a Fair Hearing even if you haven't filed a complaint or grievance with MHC and/or if a health care

service you or your doctor requested has been denied, delayed, or modified. You may request a State Fair Hearing by contacting the California Department of Social Services (CDSS) within ninety (90) days. You may write or call CDSS, toll-free, at any time during the grievance process, at the following address and telephone number:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 1937
Sacramento, CA 94244-2340
(800) 952-5253
(800) 952-8349 (TDD)

You have the right to bring someone who knows about your case to attend the hearing with you, if you wish. You may also seek legal counsel to represent you. For more information on obtaining free legal aid, contact CDSS at their toll-free number.

If you are currently receiving a medical service that is going to be reduced or stopped, you may continue to receive the same medical service until the hearing, as long as you request the hearing before the effective date of the action.

You or your provider may request an Expedited State fair Hearing by calling, writing or faxing:

Department of Social Services
Expedited Hearing Unit
744 P Street, MS 19-65
Sacramento, CA 95814
(916) 229-4267 (fax)

MHC or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function. When Expedited Hearing Unit determines that your appeal satisfies the expedite criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Fair Hearing as described above.

***External Independent Review**

Experimental and investigational therapies may be denied when determined not to be medically necessary. However, California law entitles you to request and obtain an external independent review of that coverage decision through the independent medical review (IMR) process administered by the Department of Managed Health Care (DMHC) if your physician certifies that you have a life-threatening or seriously debilitating condition and further certifies that standard therapies have not been effective or do not exist with respect to your condition, or there is no more beneficial therapy than the therapy proposed. If experimental and investigational therapies are denied, we will notify you within five (5) days of your right to request and obtain an external independent review of that decision by an entity accredited by the State of California and you may contact MHC at (888) 665-4621 Monday through Friday, 7:00 a.m. to 7:00 p.m. for information on this subject.

External independent review of a denial of experimental or investigational therapies will be completed within thirty (30) days of your request for review. However, if your physician determines that delay in the proposed therapy would be harmful if not promptly initiated, the external independent review may be expedited to provide a determination within seven (7) days of your request for expedited review.

You will be eligible to participate in MHC's external independent review system to examine a coverage decision regarding experimental and investigational therapies if you meet all of the following eligibility criteria:

1. You have either:
 - A. A life-threatening condition, which includes either (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival; or
 - B. A seriously debilitating condition, which means diseases or conditions that cause major irreversible morbidity; and
2. Your physician certifies that you have a condition, as defined in paragraph (1) above, for which standard therapies have not been effective in improving your condition, would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by MHC than the therapy proposed pursuant to paragraph (3) below; and
3. Either:
 - A. Your physician, who is under contract with or employed by MHC, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to you than any available standard therapies, or
 - B. You, or your physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d) of Health and Safety Code Section 1370.4, is likely to be more beneficial for you than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require MHC to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to MHC contract; and you have been denied coverage by MHC for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3) above; and
4. The specific drug, device, procedure or other therapy recommended pursuant to paragraph (3) above would be a covered service, except for MHC's determination that the therapy is experimental or investigational.

Please note that you will have the right to submit evidence in support of your request for external independent review. You should also be aware that the external independent review system does not replace MHC's grievance process. Rather, the external independent review system is available in addition to MHC's grievance process.

***Department of Health Care Services (DHCS) Assistance**

The California Department of Health Care Services (DHCS) is available to provide assistance in investigating and resolving any complaints or grievances you may have regarding your care and services. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman toll-free at (888) 452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m. or dial 711 for TTY assistance.

State Regulations Available

State regulations, including those covering state hearings, are available at the local office of the County Welfare Department.

Authorized Representative

Members can represent themselves at the state hearing. They can also be represented by a friend, attorney, or any other person, but are expected to arrange for the representative themselves.

Members can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952-5253.

MEMBER GRIEVANCE

The Department of Managed Health Care (DMHC) has amended the California Knox-Keene Health Care Service Plan Act pertaining to health plan member grievance procedures. Under this amendment, health plans are required to distribute the Plan's Member Grievance Procedures and Member Grievance/Complaint Forms to participating Providers/Practitioners.

Potential Quality of Care Issue

MHC recognizes that PQOCs may be identified through a multitude of inputs internally and externally, including Provider/Practitioner grievances or complaints and member grievances or complaints. For this reason, MHC's Quality Improvement Program includes input from both Provider Services and Member Services to identify both individual or incident-specific PQOCs, as well as identifying specific trends.

Member Grievance System

MHC members' grievances are addressed through MHC's internal grievance process. A member grievance is defined as member expression of any dissatisfaction, or concern that does not involve a prior determination or inquiry that was not resolved to the member's satisfaction. Examples of this include, but are not limited to appointment/office waiting time, Provider/Practitioner behavior and demeanor, adequacy of facilities, operations, and service. MHC will investigate member grievances, attempt to resolve the concerns, and take action as appropriate resolutions and findings are considered confidential and are privileged under California law. A member must not be discriminated against because he/she has filed a member grievance.

Member Grievance Submission

Member grievances may be submitted to MHC verbally, via email, on the MHC website, or in writing. Members or the Provider/Practitioner on behalf of the member may call the MHC Member Services Department for assistance in lodging a grievance. Members may obtain a

complaint form from their Primary Care Practitioner's (PCP's) office, the MHC website, or they may call the MHC Member Services Department to receive these forms. Once the member grievance is received by the Member Services Department, the grievance is submitted to the appropriate departmental contact for investigation.

MHC will provide the member with written notification acknowledging the member grievance within five (5) working days of its receipt. The member will be informed in writing of the proposed resolution or outcome of the grievance within thirty (30) days.

It is important to note that a member grievance may be a potential quality of care or service issue and PCPs, as well as their office staff, should be ready to assist a member with needed information. As a PCP, you must have MHC grievance forms in your office conveniently located for your members or they can also be found on the MHC website. If you need to order grievance forms, please contact MHC's Provider Services Department at (888) 665-4621.

Member complaints may include, but are not limited to:

- Excessive waiting time in a Provider/Practitioner's office.
- Inappropriate behavior and/or demeanor (PCP's/Office Staff's).
- Denied services. Clinical grievance subject to member/Provider/Practitioner appeal of the UM decision and expedited appeal of the UM decision.
- Inadequacy of the facilities, including appearance.
- Any problem that the member is having with MHC or their IPA/Medical Group, contracted Providers/Practitioners.
- Members billed for covered services.

MOLINA HEALTHCARE'S OMBUDSMAN PROGRAM

Providers/Practitioners

A Provider/Practitioner with a concern, question, or complaint should contact his/her MHC Provider Services Representative by calling the Provider Services Department at (888) 665-4621.

Should the concern, question or complaint not be addressed to the Provider/Practitioner's satisfaction, the Provider/Practitioner may call the MHC Ombudsman toll-free at (877) 665-4627 or write to the following address:

Molina Healthcare of California
Ombudsman Program
200 Oceangate, Suite 100
Long Beach, CA 90802

The Ombudsman attempts to ensure that MHC has made an appropriate effort to address Provider/ Practitioner concerns and provide quality customer service.

The Ombudsman is not a substitute for any MHC department or process. As previously stated, Providers/Practitioners should first contact Provider Services before seeking Ombudsman assistance.

Health Plan Members

If a MHC member has a concern, question, or complaint related to his health care, the member should first contact the Member Services Department at (888) 665-4621, Monday-Friday 7:00 am to 7:00 pm.

In the event a member is unsure of how to proceed with a concern and/or believes Member Services did not fully understand his/her concern, the member may call the Ombudsman at (877) 665-4627. The member may also write to:

Molina Healthcare of California
Ombudsman Program
200 Oceangate, Suite 100
Long Beach, CA 90802

The Ombudsman attempts to ensure that MHC has made an appropriate effort to address member concerns and provide members with quality customer service.

The Ombudsman is not a substitute for any MHC department or process. As previously stated, members should first contact the Member Services Department before seeking Ombudsman assistance.

7.0 HEALTHCARE SERVICES: UTILIZATION MANAGEMENT

HEALTHCARE SERVICES (HCS) PROGRAM

MHC's Healthcare Services (HCS) Program strives for full integration of physical health, behavioral health, long-term services and support (LTSS); and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. The HCS program includes Case Management Care Access and Monitoring (CAM), and Delegation Oversight (DOS). CAM processes (e.g. Prior Authorization & Concurrent Review), ensure appropriate and effective utilization of services, and the MHC Transitions Program, which ensures members receive the support they need when moving from one care setting to another. Mental health, chemical dependency, and long-term care are integrated throughout all aspects of the HCS program.

MHC's Delegation Oversight Department (DOS) staff maintains the responsibility for coordination and performance of pre-delegation and annual delegated oversight audits and monitoring of all IPAs / Medical Groups and health plan partners delegated for UM and /or CR functions.

Communication and Availability of HCS Staff to Members and Practitioners

MHC HCS staff is accessible through at (800) 526-8196 during normal business hours, Monday through Friday (except for Holidays) from 8:30am to 5:30pm for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to members and providers 24 hours a day, seven days a week at (888) 275-8750. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff members identify themselves by providing their first name, job title, and organization.

CARE ACCESS AND MONITORING (UTILIZATION MANAGEMENT) PRIOR AUTHORIZATION AND CONCURRENT REVIEW

Levels of Administrative and Clinical Review

Molina Healthcare (MHC) reviews and approves or denies plan coverage for various services – inpatient, outpatient, medical supplies, equipment, and selected medications. The review types are:

- Administrative (e.g., eligibility, appropriate vendor or participating provider, covered

- service)
- Clinical (e.g., medically necessary).

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well. All Organization Determination/Authorization requests that may lead to denial are reviewed by a health professional at MHC (medical director, pharmacy director, or appropriately licensed delegate).

All staff involved in the review process has an updated Organization Determination/Authorization requirements list of services and procedures that require Pre-Service Organization Determination/Authorization.

The Organization Determination/Authorization requirements, timelines and procedures are published later in the Provider Manual and available on the MHC Provider Website. In addition, MHC's provider training includes information on the UM processes and Organization Determination/Authorization requirements.

A. Initial Administrative Review

Coordinators conduct initial administrative type reviews. They ensure that the information required to process a clinical review is requested and obtained. They verify member eligibility and status of the requested provider's participation with MHC. The qualification of Coordinators includes a high school education and experience in the medical field, preferably in managed care positions.

Coordinators work with requesting providers to enter necessary information into the UM/CM information system (QNXT and MAPD). They monitor processing times for requests and assure that review requests are completed within established time frames.

Coordinators can approve requests for selected services, according to specified auto approval lists developed and approved by the HCS UM Director and Medical Directors. If a request is not on these lists, it is sent for clinical review, as described below.

B. Initial Clinical Review

Clinical Staff conduct the initial clinical review of health care service requests against medical appropriateness criteria. RNs, LPNs/LVNs, or other health professionals are responsible for completing this initial review.

Qualifications include:

- Current State licensure if applicable;
- Adequate training to utilize medical appropriateness criteria and applicable review standards or medical policy;
- Clinically supported by a licensed physician or clinical peer.

UM Clinical Staff can approve requests that meet medical appropriateness criteria. If a request does not meet criteria, the request is reviewed by a Medical Director.

C. Health Professional Review

Medical Directors conduct clinical review of services that do not meet initial clinical review appropriateness criteria. The Medical Director or Pharmacy Director reviews requests for medical necessity on all medication that does not meet initial review criteria. In addition, some services have a specific requirement for Organization Determination/ Authorizations by a health professional, as noted by medical policy.

Qualifications include:

- Current non-restricted license to practice medicine and free of any sanctions from Medicaid or Medicare;
- Adequate training to utilize medical appropriateness criteria and other applicable review standards or medical policy;
- Ability to review cases for which a clinical decision cannot be made by the first level reviewer;
- Reasonable availability, i.e. within one business day, to discuss clinical determinations with the attending or ordering physician

D. Specialist Clinical Review

Consultations and appeal reviews may require additional clinical review by appropriately credentialed specialists. Specialist reviewers should be trained in the same or similar specialty to the requesting practitioner.

Qualifications include:

- Current non-restricted license to practice medicine or related health profession and free of any sanctions from Medicaid or Medicare;
- Board certification in the same or similar specialty that usually manages the medical condition, procedure or treatment under review;
- Familiar with appropriate care of patients similar to the member involved in the review;
- Oriented to the principles and procedures of the HCS Program, the medical appropriateness criteria and other standards or medical policy.

Review Criteria

MHC utilizes standardized nationally recognized review criteria that are based on sound scientific medical evidence for making decisions concerning medical necessity and appropriateness of services. The appropriate use of criteria is incorporated into all phases of the utilization decision making process by licensed staff and Medical Directors. The criteria sources used include but may not be limited to:

- CMS Medicare Coverage Guidelines, Local and National Coverage Determinations, Medicare Benefit Policy Manual;
- Medi-Cal Coverage Guidelines;
- Corporate Guidance Documents addressing new or existing technology;
- McKesson InterQual[®] Criteria/Thomson's Length of Stay Guidelines by Diagnosis and DRG;
- Hayes Medical Technology Directory;
- Apollo Managed Care Managing Physical/Occupational Therapy and Rehabilitation Care Manual;
- Algorithms and guidelines from recognized professional societies;
- Advice from authoritative review articles and textbooks.

- State-mandated long term care assessment tools which determine eligibility for and authorization of LTSS and waiver services

MHC describes medically necessary services as services that:

Medicare Services: Are reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395y;

Medi-Cal Services: Are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as under Title 22 California Code of Regulations (CCR) Section 51303.

Where Medicare and Medi-Cal Benefits Overlap (e.g., durable medical equipment services) the health plan will apply the definition of medical necessity that is the more generous of the applicable Medicare and Medi-Cal standards.

INPATIENT CRITERIA

InterQual[®] criteria are utilized for inpatient hospital and concurrent review. Both intensity of service and severity of illness criteria are utilized to determine appropriateness of the admission and to monitor the length of stay. Clinical staff conducts medical necessity reviews telephonically or on-site for all admissions.

The InterQual[®] criteria are reviewed and purchased annually. Criteria are applied based on the needs of individual members and characteristics of the local delivery system.

Emergency/Urgent Services

MHC provides coverage for all emergency/urgent services without an Organization Determination / Authorization per all regulatory requirements. Inpatient admissions resulting from an emergency service require notification to MHC the next business day.

Medical Policy

MHC develops internally produced medical policy criteria. Medical policy may be developed for medical, surgical, diagnostic, pharmacy or other services. Medical policies are reviewed, modified and adopted by the UMC at least annually. Medical policies are derived from one or more of the following:

- Current medical literature and peer reviewed publications;
- Existing government and public sector guidelines;
- Commercially available policies;
- Physician comments;
- Community standards of medical practice;
- Standard practice of Health Contractors.

Medical policies are also available and shared with practitioners upon request. Important new policies may be distributed in the practitioners’ publication as they are implemented.

Information Sources

When evaluating requests for approval, at a minimum, MHC requires the following information:

- Member demographics and eligibility information;
- Age;
- Co-morbidities;
- Complications;
- History of symptoms and results of physical examination;
- Results of clinical evaluation including appropriate lab and radiology results, co-morbidities and complications;
- Relevant Primary Care Physician (PCP) and/or specialist progress notes of treatment or consultations;
- Psychosocial situation;
- Home environment, when applicable;
- Other information as required by criteria and/or algorithms.

MHC staff also considers characteristics of the local delivery system available for the specific member, such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the service area to support the member after hospital discharge;
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed;
- Local hospitals' ability to provide all recommended services within the estimated length of stay;
- Any available home and community resources.

Timeliness of HCS Organization Determination/Authorizations

The policy of MHC is to adhere to the following standards for timeliness of Care Access and Monitoring determinations (UM) based on regulatory requirements:

Medi-Cal Timeliness Standards

UM Decision Needed	Decision Time Frame
Routine (non-expedited) Pre-service Determinations	Within five (5) business days of receiving the medical record information required to evaluate the medical necessity and appropriateness, but no longer than fourteen (14) calendar days of receipt of the request
Expedited/Urgent Determination	Within seventy-two (72) hours of receipt of the request
Urgent Concurrent Review	Within twenty-four (24) hours of receipt of request
Post Stabilization Care	MHC's MD will respond within thirty (30) minutes of reported service request or service is deemed approved
Emergency Care	No Prior Authorization is Required
Post Service/Retrospective	Within thirty (30) calendar days from receipt of request

Providers are initially notified by fax or telephone within twenty-four (24) hours of any denial or modification of a service request. The initial notification is followed up in writing within two (2) business days of the decision to deny or modify any service request.

Members are notified in writing within two (2) business days of all decisions to deny or modify requested services. Providers/Practitioners who wish to discuss denial or modification of services may contact the MHC Medical Director at (800) 526-8196.

Clinical Criteria used in a denial or modification decision may be requested by calling (800) 526-8196.

UM decision making is based only on appropriateness of care and service and existence of coverage. MHC does not specifically reward Providers/Practitioners or other individuals for issuing denials of coverage or service care. MHC does not provide financial incentives for UM decision makers and does not encourage decisions that result in under-utilization.

Upon approval of the service request, the PCP's office staff will assist the member in scheduling an appointment with the approved Provider/Practitioner. The PCP or his staff will instruct the member to take a copy of the authorization form and / or number to the requested Provider/Practitioner.

MHC may never require authorization for the following services:

- Emergency Room including emergency behavioral health care
- Urgent Care Services including urgent care crisis stabilization, including mental health
- Nurse midwife services
- Family Planning Services
- Preventive Care
- Basic OB/Prenatal Care
- Sexually Transmitted Disease

- HIV Testing & Counseling
- Sensitive and confidential services (e.g. services related to sexual assault, drug and alcohol abuse for children aged 12 or over)
- Therapeutic and elective pregnancy termination
- Annual Well Woman Exam
- Optometry and diabetic retinal exam

Out-of-Network Services

In the event that a qualified specialist is not available within the contracted network; MHC's HCS staff will coordinate the medically necessary services with an appropriately licensed and credentialed out-of-network (OON) specialist. MHC will offer the OON provider an opportunity to contract with the health plan contingent on the provider meeting all credentialing standards. In the event that the Member's PCP is affiliated with an IPA / Medical Group MHC's HCS staff will coordinate with the IPA / MGs UM department.

MHC's comprehensive methods of review and authorization include the following processes:

Direct Referral

The Direct Referral process allows PCPs to provide direct access to a contracted network specialist. To ensure timely appointments and clarify medical necessity of the PCP referral; the PCP forwards a copy of the direct referral form and supporting medical records to the contracted network specialist.

For delegated Medical Groups/IPAs, please refer to your Medical Group/IPA contract for specific requirements for referrals/authorizations.

Pre-Service Organization Determinations/Authorizations

Pre-service review provides an opportunity to determine medical necessity and appropriateness of services, procedures and equipment prior to provision of the service. It is also an opportunity to determine if the services, procedures or equipment are a covered benefit of the member's plan and will be provided by a contracted entity.

Requests for pre-service Organization Determination / Authorizations are reviewed against established medical policy criteria. Pre-service review is completed by clinical staff and, when required, a Medical Director or other appropriate health professional. When appropriate the Medical Director or other appropriate health professional will consult with the requesting provider. Health professionals make all denial determinations. The member, practitioner, PCP, and facility (if indicated) are notified of the adverse determination in writing and, as needed, by telephone.

Procedures or Services requiring pre-service authorizations are

published: <http://www.MolinaHealthcare.com/medicaid/providers/ca/forms/Pages/fuf.aspx>

If you are contracted with MHC through an IPA/Medical Group please refer to your IPA/MG Prior Authorization requirements.

MHC conducts admission review within twenty four (24) hours of notification of admission (or next business day) to ensure the admission to an acute care hospital is appropriate/medically indicated in accordance with the illness or condition or to confirm information obtained during

prior authorization of elective admissions. Notification of admissions and requests for review may be by telephone or fax. If the admission does not meet criteria for medical necessity as an inpatient, the HCS staff will negotiate a lower level of care or refer the case to a Medical Director for determination.

Notification of Admissions

All elective and emergency inpatient admissions must be reported to MHC within twenty four (24) hours of the admission (or the next business day). These notifications can be submitted by faxing the patient's admission face sheet to: (877) 708-2110.

Concurrent/Continued Stay Review

MHC performs concurrent review to determine medical necessity and appropriateness of a continued inpatient stay. The goal of concurrent review is to identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. InterQual[®] criteria are used as a guideline in performing concurrent review activities. MHC conducts concurrent review throughout the member's stay to assure appropriate transition of care.

The clinical staff collaborates with hospital staff, practitioners and their representatives to ensure that discharge needs are met in a timely manner and continuity of service is provided.

Assessments are conducted concurrently, by telephone or fax. Objectives of concurrent review:

- Services are timely and efficient;
- Determine that a comprehensive treatment plan is established;
- Member is not being discharged prematurely;
- Member is transferred to alternate levels of care when clinically indicated;
- Effective planning and communication of discharge planning/Transition of care;
- Members appropriate for Case Management are identified and referred

Hospital UM/DCP staff is required to call in continued stay updates to: Inpatient Review Department: (800) 526-8196 or (866) 553-9263

Discharge Planning Review

Discharge planning begins as early as possible during an inpatient admission. Such planning is designed to identify and initiate cost effective, quality driven treatment intervention for post - hospital care needs.

Discharge planning involves a process of communicating with hospitals and practitioners to ensure that a member's needs are met upon hospital discharge, and that the discharge occurs in a timely manner.

The clinical staff is responsible for collaborating with hospital discharge planning to facilitate an appropriate discharge plan for the member. The clinical staff reviews the medical necessity and appropriateness for select post discharge services including home health, infusion therapy, durable medical equipment, skilled nursing facility and rehabilitative services.

All hospitalized members receive a discharge review for discharge date, setting, and procedures performed. Emphasis is placed on an appropriate discharge plan to reduce readmissions.

The clinical staff provides a post inpatient discharge follow-up call to members, to support the discharge plan prescribed by the member's physician. The purpose is to assess the member's understanding of their discharge instructions, confirm the necessary follow-up appointments have been scheduled, confirm prescriptions have been filled, and assess the need for further interventions. Post discharge follow up letters are sent to all members and their PCPs after an inpatient admission.

Members with certain conditions may receive up to 30 days of post discharge support from MHC's Care Transition staff.

Retrospective Review

Retrospective Review is a review process performed by the MHC's Medical Claim Review staff, after services have been rendered, to determine:

- If unauthorized services were medically necessary/appropriate;
- If services were rendered at the appropriate level of care and in a timely manner;
- If services were emergent or elective in nature; authorization was obtained by MHC delegated agent
- If there is documented evidence that the services were approved by MHC's delegated partner.

Skilled Nursing or Rehabilitation Facility Review

When a member is transferred or admitted to a Skilled Nursing Facility (SNF) or Acute Rehab Facility, MHC uses Title 22 and/or Medicare SNF criteria and guidelines to determine appropriate level of care. All admissions to SNF and Acute Rehab Facilities require authorization by the MHC UM Department.

Eligibility

Authorization is based on member eligibility at the time of request and is verified by the Utilization Management staff. Providers / Practitioners are encouraged to verify member eligibility at the time the service is rendered.

Benefits

Benefit coverage for a requested service is verified by the UM staff during the authorization process.

Referral to Non-Participating Providers/Practitioners or Non-Contracted Facilities

Except in true emergencies, MHC provides coverage for only those services rendered by contracted Providers/Practitioners and facilities, the exceptions are:

- MHC is notified, approves, and authorizes the referral in advance. In these instances, the UM Prior Authorization Department will issue an authorization number for the services to be provided. Prior approval must be obtained by the Provider/Practitioner recommending an out of plan referral before arrangements have been made for those services. To obtain an authorization number, contact the MHC Authorization Department at (800) 526-8196; fax (800) 811-4804.

Service Request Form

The Service Request Form must be completed and an authorization obtained for all services described above as requiring prior authorization **before the service is provided**, except in emergencies.

For an authorization to be valid for claims payment the following conditions must be met:

- The member must be currently enrolled with MHC.
- The member must be assigned to the PCP initiating the primary referral.
- The member must receive authorized services within ninety (90) days of the authorization date.
- **A Prior Authorization number must be obtained from MHC prior to services being rendered as described above (except in emergencies).**
- MHC retains the right to retrospectively review inpatient and specialist claims to identify inappropriate consultations and procedures. The right to deny such consultations and procedures is also reserved.
- All inpatient services must have a prior authorization number which is issued by the MHC's Utilization Management Department.
- Inpatient Admission Notification (800) 526-8196
 - Face Sheet Fax (877) 708-2110
 - Clinical Review Fax (866) 553-9263

Completion of a Service Request Form

- A thoroughly completed Service Request Form is essential to assure a prompt authorization.
- All shaded areas are to be completed by the referring/ordering entity.
- A copy of pertinent clinical notes, labs, imaging, etc. may be attached and substituted for the Clinical History segment of the Service Request Form.
- To assure maximum benefit from a referral, the requesting provider must clearly state the purpose of the service request.
- The form should be transmitted by fax to MHC's Prior Authorization Department for review and assignment of an authorization number.

PRIOR AUTHORIZATION REQUESTS

Primary Care Practitioners (PCPs)

- The PCP is always the initial source of care for members. A member may see the PCP without a referral and the PCP may perform essential services in the office environment.
- Elective office procedures performed by the PCPs may require authorization.
- Prior Authorization may be required for necessary member services ordered by the PCP which cannot be performed in the office (Please reference MHC's PA Requirement Guide).
- If the PCP determines that a specialist is necessary for consultation or care of the patient, the PCP must complete a Referral Form (Direct Referral Forms can be found on MHC's Provider website).
- Prior Authorization is not required from MHC for direct referrals and/or follow-up

consultations to contracted specialists.

- Referrals are only made to specialists in the MHC Network. Exceptions will be made only in rare circumstances and then only with the prior approval of the MHC Medical Director.
- Complete referrals are essential, stating exactly what is to be done and including any clinical information and previous diagnostic testing for the specialty provider's/practitioner's review.
- A system within the PCP's practice should be developed to assure that written responses from specialty referrals are received and incorporated into the Member's medical record, e.g. a Specialty Log.

NOTE: As described in the Benefits and Covered Services Section of this Provider Manual, certain benefits and services are available to members without the necessity of PCP referral, e.g. Obstetrics, Optometry, Family Planning, etc.

LAB REFERRALS

UNILAB/QUEST

Laboratory Services are provided through various methods, depending upon the Provider/Practitioner's or IPA/Medical Group's relationship with the Plan. Refer to the following table for reference when accessing laboratory services for your patients:

	MHC DIRECT PCP	MHC DIRECT SPECIALIST	MHC MEDICAL GROUP PCP	MHC PCP THROUGH IPA/MEDICAL GROUP
QUEST	✓	✓	✓	
Follow IPA Requirements				✓

As outlined in the table above, MHC's direct contracted PCPs, Direct contracted Specialists, and MHC Medical Group PCPs must use QUEST for MHC members. Providers/Practitioners should direct MHC patients to a QUEST draw station. Providers/Practitioners may call QUEST for laboratory pick-up.

All STAT laboratory tests will be picked up as soon as possible and results will be called in or faxed as soon as the tests are completed. Most routine laboratory tests will be processed within forty eight (48) hours. For further information regarding services, draw station locations, supplies, or answers to technical questions, please contact Quest directly: www.questdiagnostics.com.

SPECIALISTS REFERRALS

- A specialist may see a MHC member only upon an initial referral from the member's assigned PCP or as a secondary consultant from the primary referred specialist, except in a Medical Emergency.

- If there is any question regarding the scope of the referral, the PCP should be contacted for clarification.
- The PCP will specify the type of referral:
 - Consultation for diagnostic purposes
 - Consultation to recommend treatment plan
 - Consultation and request to assume care
- When the member is referred for “Consultation to Recommend Treatment Plan” the PCP will specify on the referral form if:
 - The referral is for a consultation visit only, or
 - The referral is for consultation plus one follow-up visit.

Only those diagnostic procedures, tests, and treatments specifically related to the consultation, may be performed by the Specialist.

If the specialist determines that a secondary specialist who is out of the MHC Network is required, a Prior Authorization from MHC is required.

MHC is ONLY financially responsible for those services which are Medically Necessary and specified in the Referral/Service Request form by the PCP to Specialist (or Referred Specialist to Secondary Specialist), and have been Prior Authorized by MHC.

- Verbal communication from the PCP should be provided on any urgent referrals.
- A written response should be provided to the CP within three (3) weeks of care for inclusion in the member’s medical record.
- If the services require a Prior Authorization from MHC the Prior Authorization number must be clearly written on the bill submitted to MHC:
 Molina Healthcare, CA
 200 Oceangate, Suite 100
 Long Beach, CA, 90802
 Attn: Claims Department

If the member is Medicare eligible or has other insurance, submit the claim to that entity first, then to MHC with the appropriate EOB.

CONTINUITY OF MEMBER CARE

All contracted Providers/Practitioners within MHC’s networks must ensure that members receive medically necessary health care services in a timely manner without undue interruption.

The cornerstone of continuity of care is the maintenance of a single, confidential medical record for each patient. This record includes documentation of all pertinent information regarding medical services rendered in the Primary Care Practitioner’s (PCP) office or other settings, such as, hospital emergency departments, inpatient and outpatient hospital facilities, specialist offices, the patient’s home (home health), laboratory and imaging facilities. All contracted Providers/Practitioners must have systems in place to ensure the following:

- Maintenance of a confidential medical record.

- Monitoring of patients with ongoing medical conditions.
- Appropriate referral of patients in need of specialty services.
- Documentation of referral services in the member's medical record.
- Forwarding of pertinent information or findings to specialist.
- Entering findings of specialist in the member's medical record.
- Documentation of care rendered in the emergency or urgent care facility in the medical record.
- Documentation of hospital discharge summaries and operative reports in the medical record.
- Coordination of post hospital follow-up, discharge planning, and aftercare.

Routine Medical Care

The member's PCP is responsible for providing routine medical care to members, following up on missed appointments, prescribing diagnostic tests and procedures, referrals, and/or laboratory tests. The PCP also ensures that each newly enrolled member receives an initial health assessment within ninety (90) days of enrollment.

Referrals

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Upon initiation of the referral, the PCP is responsible for initiating the referral tracking system.

Second Medical/Surgical Opinion

A member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- MHC members may request a second opinion through their PCP or MHC's Customer Support Center. MHC'S's Customer Support Center will assist the member in coordinating the second opinion request with the member's PCP, specialist, and/or IPA/Medical Group.
- Members assigned to a delegated IPA/Medical Group will have their second opinion request submitted to and reviewed by that IPA/Medical Group's Medical Director.
- Members assigned to a direct contracted PCP or Non-Capitated / UM Delegated MHC Medical Group PCP will have their second opinion request submitted to and reviewed by MHC's Medical Director.
- Second Opinion requests will be reviewed and provided written approval or denial within forty eight (48) hours of request receipt. In cases where the request identifies an urgent or emergent need, formal approval or denial will be provided within one (1) working day.
- If the request for second medical/surgical opinion is denied, both the member and Provider/Practitioner have the opportunity to appeal the decision through the Member Appeals Process.
- If the requested specialty care Provider/Practitioner or service is not available within the MHC network; an approval to an out of network Provider/Practitioner will be facilitated by MHC HCS staff or the IPA/Medical Group's Utilization Management Department.
- Only one request for a second medical/surgical opinion will be approved for the same

episode of treatment. This applies to both the in network and out of network requests for second medical/surgical opinion.

Upon approval of the request for a second medical/surgical opinion, the PCP's office staff will assist the member in scheduling an appointment with the second opinion Provider/Practitioner for the member. The PCP or his staff will instruct the member to take a copy of the authorization form and pertinent medical records to the second opinion Provider/Practitioner.

CONTINUITY OF CARE – NEW & CURRENT MEMBERS

When Continuity of Care is a result of a Provider/Practitioner Contract Termination:

- Members shall be notified at least thirty (30) calendar days prior to the effective date of a Provider/Practitioner contract termination, or within fourteen (14) calendar days prior to the change in cases of unforeseeable circumstances. In cases of unforeseeable circumstances, the Compliance Department will coordinate with the Regulatory Contract Managers for approval. MHC will adhere to the most stringent regulatory standard for all lines of business.
- This policy shall encompass all members assigned to a PCP or that have been treated by a Specialist Provider/Practitioner any time during the eight (8) months preceding the effective termination date, currently in treatment or open authorizations.
- MHC HCS staff shall arrange for, upon request by the member or a Provider/Practitioner on behalf of the member, for continuity of care by a terminated Provider/Practitioner or a Provider/Practitioner that has changed Medical Group/Independent Practitioner Association (IPA) affiliation.

Conditions for Continuation of Services:

- Newly enrolled SPD Member access to existing out-of-network practitioner / provider: MHC's UM department will ensure continued access for up to 12 months to an out-of-network provider for new SPD members who have an established on-going relationship if there are no quality of care issues with the provider and the provider agrees to accept MHC's contract or Medi-Cal FFS rates, whichever is higher.
- An acute condition for the duration of the condition (defined as a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration).
- Serious chronic condition for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, not to exceed 12 months (defined as a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:
 - (a) persists without full cure or worsens over an extended period of time, and
 - (b) requires ongoing treatment to maintain remission or prevent deterioration.
- Pregnancy condition for the duration of the condition and immediate postpartum period (a pregnancy is the three (3) trimesters of pregnancy and immediate postpartum period).
- Terminal Illness for the duration of the condition (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less).
- Care of a newborn child who age is between birth and age thirty-six (36) months not to exceed 12 months duration.

- Performance of surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment that is to occur within 180 days.
- Transition to other care for member's who are receiving approved services but whose benefit coverage will end while the members still need the medically necessary care.
- For cases involving an acute condition or a serious chronic condition, MHC will continue to provide the member with health care services in a timely and appropriate basis from the terminated Provider/Practitioner or Provider/Practitioner that has changed Medical Group/IPA affiliation, for up to ninety (90) days or a longer period if necessary, for a safe transfer to another Provider/Practitioner as determined by MHC's Medical Director, in consultation with the PCP, terminated Provider/Practitioner, and/or the receiving Medical Group/IPA, consistent with good professional practice.
- For cases involving pregnancy, MHC shall furnish the member with health care services on a timely and appropriate basis from the terminated Provider/Practitioner or Provider/Practitioner that has changed Medical Group/IPA affiliation, until postpartum services related to the delivery are completed or for a longer period if necessary, for a safe transfer to another Provider/Practitioner as determined by MHC's Medical Director, in consultation with the PCP, terminated Provider/Practitioner, and/or the receiving Medical Group/IPA, consistent with good professional practice.
- Continuity of care during an inpatient admission shall be reviewed and determined by MHC's Medical Director in consultation with the PCP, terminated Provider/Practitioner, and/or the receiving Medical Group/IPA.
- Continuity of care for outpatient services, outstanding and ongoing authorizations, for a terminated Provider/Practitioner or a Provider/Practitioner that has changed Medical Group/IPA affiliation, shall be reviewed by MHC's Medical Director in consultation with the PCP, receiving Medical Group/IPA, and other Providers/Practitioners involved with the patient's care.

TRANSITIONS OF CARE (TOC) PROGRAM

Transitions of Care staff work collaboratively with both members and providers to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This is accomplished by providing members with the tools and support that promote knowledge and self-management of their condition, and by facilitating improved member and provider understanding of roles, expectations, schedules and goals. Such transitions occur, for example, when a member moves from a home to a hospital as the result of an exacerbation of chronic conditions or moves from a hospital to a rehabilitation facility after surgery.

MHC's TOC program is administered by a MHC clinical team members and is delivered in one of two ways:

- *Transitions of Care Telephonic Coaching Program* is designed to reach a large volume of high risk members by making an inpatient hospital outreach call and three or more subsequent phone calls within a four to six week period of time from the date of the member's initial admission.
- *Healthcare Transitions Program* is designed for members to receive face-to-face contact with TOC staff – one in the hospital prior to discharge and/or one at home within 48

hours of discharge targeted at members known to have admitting diagnoses which research has shown have the highest risk for readmission to an in-patient facility. (This variation of the program is currently in place with selected hospitals in San Diego County).

The aim of the TOC programs includes; preventing avoidable hospital readmissions, optimal transitioning from one care setting to another and / or identifying an unexpected change in condition requiring further assessment and intervention. Continuity of care post discharge communications may include, but not be limited to, phone calls and follow up letters to members and their Primary Care Physicians (PCPs), specialty providers, other treating providers / practitioners as well as agencies providing long term services and supports (LTSS).

The MHC Transitions of Care Program focuses on four critical elements as the foundation to prepare members for successful transitions. Adapted from Dr. Eric Coleman's Model of Care Transitions Interventions (<http://www.caretransitions.org>) (Eric A. Coleman, MD, MPH) they include:

- Medication Management – MHC's transition staff will assist with the coordination of member medication authorizations as appropriate; provide training to members regarding their medications, and conduct medication reconciliation to avoid inadvertent medication discrepancies. Through its Pharmacy Benefit Manager (PBM), CVS Caremark, MHC will have up-to-date information readily available regarding the member's current medications and medication history.
- Personal Health Record – MHC's TOC staff will assist with completion of a portable document with pertinent member history, provider information, discharge checklist and medication record to ensure continuity across providers and settings.
- PCP and/or Specialist Appointments – MHC TOC staff re-establish the member's connection to their medical home by ensuring that an appointment has been scheduled with the member's Primary Care Physician (PCP) prior to discharge from a hospital. The goal is to arrange an appointment to occur within seven days of discharge. TOC staff will facilitate appointment scheduling with PCPs and specialists as well as transportation to ensure members keep follow-up appointments.
- Knowledge of Red Flags – MHC's transitions staff will ensure members are knowledgeable about and aware of indications that their condition is worsening and how to respond.

Transitions of Care staff function as a facilitator of interdisciplinary collaboration across the transition, engaging the member and caregivers to participate in the formation and implementation of an individualized care plan including interventions to mitigate the risk of re-hospitalization. The primary role of the transitions staff is to encourage self-management and direct communication between the member and provider rather than to function as another health care provider.

Initial contact between the transitions staff and member will be made during the inpatient stay. The MHC transitions staff will perform introductions, explain the program and describe the member's role within the program. The member may elect at this point not to participate in the program. The transitions staff will verify the provider, member address and telephone number,

and provide the member with MHC care transitions information, including contact information to access their MHC representative. All members also receive the toll-free Nurse Advice Line phone number to call if they have questions or concerns after hours.

The transitions staff will use a tool to assess the member's risk of re-hospitalization and will assist in coordinating the discharge plan, which may include authorizing home care services or assisting the member with after-treatment and therapy services.

The face-to-face/telephone visit at the member's residence or secondary facility and / or telephone calls are designed to provide continuity across the transition to empower members to actively engage in managing their care. During these visits / telephone calls, the transitions staff expands upon the information provided in the initial hospitalization contact and will assist the member with completion of their Personal Health Record, which includes their medication record. The transitions staff will also conduct medication reconciliation. A review of red flags, i.e., warning symptoms or signs that the condition is worsening, and education regarding the initial steps to manage these symptoms and when to contact their provider are discussed. The transitions staff will assess the safety of the environment, the member's support network and community connections. The transitions staff receives training in community resource referrals and will assist the member when needed with referrals for items such as food, transportation and long term services and supports. The TOC Program fits within MHC's Integrated Care Management Model, which promotes whole-person care. As the transitions program nears completion, if it is determined the member has ongoing needs, the TOC coach will refer the member to the Case Management and/or the PCP so that the member can received further assessment and interventions to address those needs going forward.

7.1 HEALTHCARE SERVICES: CASE MANAGEMENT

The Molina Healthcare Case Management (CM) Program is an integral part of the comprehensive Medical Management Program. The goal of case management is to improve the health and well-being of members, particularly those members with serious, debilitating or complex medical conditions by educating, assisting, and facilitating access to the most appropriate health care services available so that they may regain optimum health or improved functional capability, in the right settings and in a cost-effective manner. Case management involves assessment of the member's condition; determination of available benefits and resources; collaboration between Molina and providers and the development and implementation of an individualized, multidisciplinary case management plan with performance goals, monitoring and follow-up.

MHC's practitioners/providers are an integral part of the Case Management Program. The state of California requires that Primary Care Providers and Molina Healthcare provide Comprehensive Medical Case Management to each member. These services are provided by the Primary Care Provider (PCP) in collaboration with Molina to ensure the coordination of medically necessary health care services including waiver program or carved out services, the provision of preventive services in accordance with established standards and periodicity schedules, and continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. The extent of collaboration with the plan is based on the needs identified by the PCP which could include but is not limited to coordination with Care Access & Monitoring staff for authorizations, Member Services for non-medical transportation services, Pharmacy staff regarding the Molina Formulary or Case Management staff for additional support in care coordination.

Based on the needs of the member, Comprehensive Medical Case Management services are described as either Basic or Complex:

Basic Case Management services are provided by the primary care provider in collaboration with the Molina and include:

- Initial Health Assessment (IHA)
- Initial Health Education Behavioral Assessment (IHEBA)
- Identification of appropriate providers and facilities to meet member care needs (such as medical, rehabilitation, and support services)
- Direct communication between the provider and member/family
- Member and family education, including healthy lifestyle changes when warranted
- Coordination of carved out and linked services, and referral to appropriate community resources and other agencies, including but not limited to California Children's Services (CCS), Regional Centers, In Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), etc.
- **Complex Case Management** services are provided by the primary care provider, in collaboration with the Plan, and include:

- Basic Case Management Services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
- Intense coordination of resources to ensure member regains optimal health or improved functionality
- With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
- Services for Seniors and Persons with Disabilities (SPD) beneficiaries must include the concepts of Person-Centered Planning

Identifying Members for Case Management

All members receive Basic Case Management services from the PCP with varying collaboration from the Plan based on the member's needs. For members who need greater involvement from Plan case management staff (such as member with Medicare and Medi-Cal and Seniors & Persons with Disabilities), Molina Healthcare proactively identifies members who need Case Management from MHC using a variety of clinical care processes and data sources including but not limited to utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical and administrative data (claims data, encounter data, hospital admission/discharge data, pharmacy data obtained from Pharmacy Benefit Management (PBM) organization and/or State, data collected through the Care Access and Monitoring (CAM) process (including prior authorization data, concurrent review data), laboratory results, reinsurance reports, frequent emergency department (ED) use reports and/or predictive modeling software programs/reports), and any other available data. In addition, MHC's case management software platform system contains a rules engine that identifies and stratifies members that are appropriate candidates for CM through system-based rules that consider certain medical conditions, utilization, claims, pharmacy, and laboratory data.

In addition, Molina Healthcare provides multiple avenues for members to be referred to the Plan for case management services beyond what the PCP provides, including telephone, fax or email:

FAX: (562) 499-6105 PHONE: (800) 526-8196 ext. 127604
MHCCaseManagement@MolinaHealthCare.Com

Molina welcomes referrals from PCPs, hospital discharge planners, social workers, CCS case managers, Early Start staff, members and/or member's family/caregiver, specialty physician, and other practitioners. CM Program and contact information is also available from Member Services, 24 hour Nurse Advice Line and in the Health Care Professionals sections on the Molina Healthcare website.

Members appropriate for Complex Case Management are those who have complex service needs and may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

Assessment and Leveling

Members who have been identified for CM by MHC are assigned to the appropriate Molina staff. New cases are prioritized and managed according to urgency. The staff reviews all available information (such as the source and reason for referral, utilization data, etc.) and contacts the member by telephone to perform an assessment. Members have the right to decline participation or to disenroll from the CM program at any time. Molina Healthcare members are assumed to be in the program unless they opt out and members cannot opt out of the Basic Case Management provided by their PCP.

The assigned CM makes three attempts to reach the member by phone on different days and times. If the member cannot be reached, the CM will attempt to find other phone numbers (e.g. from PCP office, pharmacy, hospital face sheets, etc.). If no other phone numbers are found or those other numbers yield no contact, the CM sends an “unable to contact” letter. If appropriate, the CM may also refer the member to a Community Connector who will attempt to locate the member at the physical and mailing addresses on file in Molina’s membership database. If the mail is not returned to Molina, the member does not contact Molina Healthcare within 14 calendar days, and/or the Community Connector does not locate the member it will be assumed that the member does not desire CM.

During the first contact with the member by Molina staff, an initial assessment is completed or an appointment for completing the assessment is made. The initial assessment will be initiated as expeditiously as the member’s condition requires and will be completed within 30 days of assignment. The assessment may be completed in multiple contacts. The assessment is conducted either telephonically, or during a home visit. Home visits are considered an enhancement to accurate assessment, and will be made to provide a more accurate evaluation of the member and their circumstances and needs when deemed appropriate. Molina Healthcare’s CM process includes an assessment of the member’s health status, including an evaluation of their medical, psychosocial and behavioral health situation and needs as well as condition-specific issues. The assessment provides the Molina case manager with the foundational information that is used to develop an individualized plan of care.

These assessments include the following elements based on NCQA, state and federal guidelines:

- Health status and diagnoses
- Clinical history
- Medications prescribed
- Activities of daily living, functional status, need for or use of LTSS
- Cultural and linguistic needs
- Visual and hearing needs
- Caregiver resources
- Available benefits and community resources, including carved out and linked services such as behavioral health, substance abuse, long term supportive services, California Children’s Services, Early Start, etc.
- Life-planning activities (e.g., healthcare power of attorney, advance directives)
- Body Mass Index
- Smoking
- Confidence

- Readiness to change
- Member’s desire / interest in self-directing their care
- Communication barriers with providers
- Treatment and medication adherence
- Emergency Department and inpatient use
- Primary Care Physician visits
- Living situation
- Psychosocial needs (e.g., food, clothing, employment)
- Durable medical equipment needs
- Health goals
- Mental health and
- Chemical dependency.

Based on the on the member’s responses to the initial health risk assessment, additional condition-specific health assessments may be used to determine what level/intensity of case management is needed. The case manager then works with the member to identify interventions that support member achievement of short- and long-term goals. For all levels, the focus of the interventions is to provide member education and/or to coordinate access to services which will lead to the most appropriate levels of care and utilization of health services while maintaining or improving the members’ health and functioning.

Basic Case Management				
Case Management			Complex Case Management	
PCP + Molina Care Coordination	Level 1 Health Management	Level 2 Care Interventions	Level 3 Complex	Level 4 Imminent Risk

Once a determination has been made that the member will participate in case management, the Care Manager sends the member a welcome letter. A copy of the welcome letter is also sent to the member’s primary care physician and any applicable specialty physicians.

The resulting care plan is approved by the member, maybe reviewed by the Interdisciplinary Care Team (ICT) and maintained and updated by the Case Manager as the member’s condition changes. The Case Manager also addresses barriers with the member and/or caregiver, and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

The purpose of the HCS program interventions at all levels is to ensure that the member and/or family understands and agrees with the care plan, understands the member/family/physician/case manager role in fulfilling the care plan, key self-management concepts and has the resources for implementation. All member education is consistent with nationally accepted guidelines for the particular health condition.

Level 1 – Health Management

Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions; behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems and compromise independent living. The goal is to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option, if they so choose, to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dietitians, and health educators.

Level 2 – Case Management

Case Management is provided for members who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS and other carved out and community programs/services. The goal of Case Management is to collaboratively assess the member's unique health needs, create individualized care plans (ICPs) with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes. Case Managers have direct telephonic access with members. In addition to the member, Case Management teams also include pharmacists, social workers and behavioral health professionals who are consulted regarding patient care plans. In addition to telephonic outreach to the member, the Case Manager may enlist the help of a Community Health Worker or Community Connector to meet with the member in the community for education, access or information exchange.

Level 3 – Complex Case Management

Complex Case Management is provided for members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services.

The goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of member conditions include the development of a case management plan with performance goals and identification of available benefits and resources. Case Managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis.

MHC continues to look for innovative ideas to promote health, for instance, MHC has implemented a Community Connector program for members receiving Level 2-4 Case Management. Community Connectors mimic a Community Health Worker model in order to support MHC's most vulnerable members within their home and community with social services

access and coordination. They serve as patient navigators and promote health within their own communities by providing education, advocacy and social support.

Level 4 – Imminent Risk

Level 4 focuses on members at imminent risk of an emergency department visit, an inpatient admission, or institutionalization, and offers additional high intensity, highly specialized services. These members often have been high utilizers of medical services. Members who may be candidates for organ transplant or who may be considered for other high-risk or specialized treatments (e.g. LVAD) are also placed into this level. Level 4 also includes those members who are currently institutionalized but qualify to transfer to a home or community setting. Populations most often served in Level 4 are the Dual-Eligible (Medicare/Medicaid), those with severe and persistent mental illness (SPMI), those with Dementia, and the Developmentally Delayed. These services are designed to improve member’s health status and reduce the burden of disease through education as described in Level 1.

These criteria include meeting an intensive skilled nursing (ISN) level of care, facing an imminent loss of current living arrangement, deterioration of mental or physical condition, having fragile or insufficient informal caregiver arrangements, having a terminal illness, and having multiple other high risk factors.

Comprehensive assessments of Level 4 conditions include: assessing member’s unique health needs utilizing the comprehensive assessment tools; identifying potential facility transitions and needs for LTSS referral coordination; participating in ICT meetings; creating ICPs with prioritized goals; and facilitating services that minimize barriers to care for optimal health outcomes.

If the member’s Level requires case management at a higher or lower level than the staff assigned can provide or the member’s needs require assignment to a staff person with particular subject matter expertise, the staff will discuss the findings with his/her supervisor so that the member can be assigned accordingly. For example, if a member is assessed by a case manager who is a RN with expertise in clinically complex conditions and the member’s needs are assessed to be primarily related to a behavioral health condition, the Supervisor would reassign the case to a case manager of an appropriate discipline with experience in behavioral health. Similarly, should a case manager with a Master’s in Social Work assess a member with severe heart disease who is a candidate for transplant, the Supervisor would identify a case manager with the appropriate discipline and experience.

Case Management Process / Development of a Plan of Care

The member’s PCP is the primary leader of the health team involved in the coordination and direction of care services for the member. If the member is receiving case management services from the PCP only, the plan of care is documented in the member’s medical record. If the member is also receiving case management services from Molina staff, the care plan is created within two business days of completing the assessment. The care plan is maintained in Molina’s case management software platform “Clinical Care Advance (CCA)” and a copy is sent to the PCP for review and inclusion in the medical record.

An individualized plan of care is required for each member using Person-Centered planning and treatment approaches that are collaborative and responsive to the member's health care needs. Members can choose to include any family, friends and professionals to participate in discussions or decisions regarding treatments, services or other elements of the care plan. Specific activities and interventions tailored to the needs of the individual must be included, assuring consideration for the member's or responsible party's goals, preferences and choices.

Care plans created by Molina staff in the CCA System contain Guidelines and Milestones that are used to identify member needs, actions related to those needs, desired outcomes and evaluation criteria. Guidelines in CCA are defined as a standard set of Goals and Milestones that reflect the best practices for a particular problem or diagnosis. Documentation from the member assessment as well as a variety of other sources such as physician offices, facility medical records and discharge planners in other organizations etc. will be considered in the process of case management assessment and planning. Based on member needs and preferences the case management staff will solicit input from a multidisciplinary team such as the member's PCP, specialist physician, home health provider, CCS or Regional Center liaison, and Molina subject-matter experts such as pharmacist, dietitian, social worker or Medical Director.

Molina Healthcare case management staff will:

- Ensure members receive all necessary information regarding treatment or services so that they may make informed choices.
- Follow the appropriate process for services requiring authorization with clinical review
- Discuss the care plan and/or follow up activities with the member
- Create care plans that include:
 - Problems – a minimum of one problem, two for complex members
 - Goals – An established target that a member should meet within a guideline/care plan. Short Term Goal = 60 days or less - Long Term Goal > 60 days. Complex cases contain at least one short-term goal and one long-term goal and the goals must be prioritized. Progress towards goals is assessed at least quarterly.
 - Interventions - Interventions provide the implementation of content developed to aid patients or practitioners; they may include phone calls, e-mails, mailings, coaching, home visits, advice, reminders, tools and biometric devices. Plans for continuity of care including transition of care and transfers are included and approaches to collaboration with family members, other Care Managers such as those from home health, hospice, acute or long term care, physicians, waiver programs, state case workers etc. are included as appropriate.
 - Outcome - The anticipated result of a planned intervention within a guideline in the care plan.
 - Barriers – Barriers to care will be addressed including those relative to the member's ability to achieve goals or to comply with their treatment plan. Such things as the member's lack of understanding, ability to understand, motivation, financial need, insurance issues, transportation problems, lack of family or other caregiver support,

- inadequate or inappropriate housing, social and cultural issues / isolation, and so forth may be considered.
- Resources to be utilized, including level of care - Also included in the plan will be resources to be utilized such as the Complex Care Manager, Medical Care Manager, Social Worker, Disease Care Manager, Disease Management Program, education, cultural and linguistic services, etc. Plans for continuity of care including transition of care and transfers will also be included. Approaches to collaboration with family members, other Care Manager(s) such as those from home health, hospice, acute or long term care, physicians, waiver programs, state case workers, etc. will be included as appropriate.
 - Time frames/schedules for reevaluation - will be determined and documented in the case management plan. Member progress toward goals and overcoming barriers will be assessed and documented as frequently as needed and no less than quarterly. Plan goal adjustments will be made based on the unique and changing needs of the member and will consider such things as the member's overcoming barriers to care and meeting their treatment goals. Ongoing assessment-reassessment, goal adjustment, and modification of the care plan are considered core case management activities and will be completed and documented in a timely manner. Such changes will be communicated to the member and / or caregiver and other collaborators.
 - Planning for continuity of care, including transition of care and transfers
 - Collaborative approaches to be used, including family participation.
 - A schedule for follow-up and communication with the member is documented within the care plan.
 - Member Self-Management Plan – The case manager will develop, document, and communicate a plan for member self-management that may include such things as members' monitoring and daily charting of their symptoms, activities, weight, blood pressure, glucose levels, daily activity, and their compliance with dietary and/or fluid intake, dressing changes and other prescribed therapies. Focus will be on activities that are designed to shift the focus in patient care from members receiving care from a practitioner or care team to members providing care for themselves, where appropriate.

The PCP must be an active participant in the member's Interdisciplinary Case Team (ICT). Each CM is responsible for sending the care plan to the member and their assigned PCP. We request that the PCP review every care plan and provide additional observations and information as appropriate to support the member's care coordination preferences and needs. All care plans whether they are authored by Molina staff and/or PCPs be clearly documented in the member's medical records.

Referrals to State or County Case Management Programs

When a member is identified as being eligible for a County or State supported health care program, a MHC Case Manager may assist the PCP to ensure timely referral to the appropriate program. The PCP, with the patient's/family's approval, makes the referral to the program. The PCP will coordinate primary medical care services for members who are eligible.

Case Management Process / Reassessment

The case management plan includes a schedule for reassessment of member progress towards overcoming barriers to care and goal achievement. Reassessment schedules depend on the complexity and/or stability of member's situation. For example, if the member has transitioned from one level of care to another or has experienced a significant medical (e.g. stroke) or life event (e.g. eviction leading to homelessness) that could impact their ability to manage their health. A schedule for follow-up, communication with the member and reassessment is established by the case manager. Reassessment will include the SF-12® survey every 90 days for members in Levels 2-4.

Regular meetings (case rounds) with appropriate plan leadership and Medical Director will occur as needed to evaluate the feasibility of treatment plan and progress toward goals. The member's case will also be assessed for transitional needs into or out of Complex Case Management services: at the request of the PCP or member; upon achievement of targeted outcomes; and/or upon change of healthcare setting.

Case Closure

The member will remain in Case Management until one of the following occurs: member has terminated/transferred membership from Molina Healthcare; member has expired; or member refuses or withdraws consent for case management. In addition, if the Care Manager is unable to contact member for updates and/or reassessment. If the member achieves their targeted outcomes or otherwise does not meet the criteria for Level 1, the Molina staff will perform an SF12® survey and a Case Closure letter will be sent. The PCP and member will be notified that the member can re-engage with Molina case management staff if their condition changes and case management by health plan staff is needed again.

Outcomes Evaluation / Measuring Effectiveness

MHC uses a variety of approaches to evaluate the effectiveness of the program. Member satisfaction with the MHC Case Management Program is measured at least annually via a survey of members that whose case management cases were closed or whose case is currently open to case management and have they received services for a minimum of 60 days. The survey measures the overall program and the usefulness of case management services. Areas of survey measurement include member's adherence to treatment plan, knowledge of condition, and appropriate service coordination. Member satisfaction is also measured via an analysis of member complaints related to the program. Clinical measure include Health Employer Data and Information Set (HEDIS) effectiveness of care measures and National Quality Forum measures for chronic illness. Health status and mental health status are measured based upon a comparison of SF-12® measures over time. Utilization data such as admissions, ED visits and bed days and readmission rates per thousand per year are also analyzed. Process measure also look at average cases per case manager, referral sources and reasons, decline rates, etc.

7.2 HEALTHCARE SERVICES: WOMEN'S & ADULT HEALTH SERVICES, INCLUDING PREVENTIVE CARE

PREGNANCY AND MATERNITY CARE

All pregnant and postpartum women must be offered access to the Comprehensive Perinatal Services Program (CPSP) or equivalent services. This includes the multi-disciplinary integration of health education, nutrition, and psychosocial assessments. In addition, pregnant and postpartum women have access to medical/obstetrical care, genetic counseling, case coordination/case management, individualized care plan (ICP) development with updates, trimester reassessments, and postpartum assessment to include health education, nutrition and psychosocial assessments, and medical/obstetrical care to both the common and identified high-risk pregnancy/postpartum member within sixty (60) days postpartum.

Provider/Practitioner Responsibilities

OB care Providers/Practitioners are strongly encouraged to be CPSP certified or have a formal relationship with a CPSP certified Provider/Practitioner for the provision of CPSP support services. All pregnant members shall be referred and assigned to CPSP certified Providers/Practitioners for CPSP services, whenever possible. The CPSP Providers/Practitioners shall be involved with the following:

- Integration of clinical health education, nutrition, and psychosocial assessment
- Medical obstetrical care, genetic counseling, and case coordination/management
- Use of appropriate documentation and care planning tools
- Submission of encounter and outcomes data

CPSP Certified Providers/Practitioners of Perinatal Services

- CPSP Certified Providers/Practitioners shall be responsible for providing and complying with all CPSP service requirements for their pregnant and postpartum members up to sixty (60) days after delivery.
- CPSP Certified Providers/Practitioners shall be responsible for complying with MHC's policy and procedure and Comprehensive Perinatal Services Program (CPSP) requirements and standards including: use of appropriate assessment, documentation, and care planning tools; submission of reporting forms (i.e. Pregnancy Notification Report).
- All CPSP Providers/Practitioners will receive information on how to obtain copies of CPSP's "Steps to Take" materials which provide helpful information to staff members to effectively assess, provide intervention for common pregnancy related conditions/discomforts and how to appropriately refer pregnant members to all appropriate services.

Non-CPSP Certified Providers/Practitioners of Perinatal Services

Non-CPSP Providers/Practitioners **must** comply with MHC policy and procedures and standards including:

- Use of appropriate assessment, documentation, and care planning tools
- Submission of reporting forms (e.g. Pregnancy Notification Report)
- Employment of appropriate, qualified staff (e.g. CPHW)

MHC's Perinatal Services Staff may also perform audits/reviews on, but not limited to, the following:

- Member satisfaction questionnaire
- Member complaints

MHC and the Local Health Departments shall provide a consolidated effort to promote, encourage, and assist all Non-CPSP Providers/Practitioners in obtaining CPSP certification through the Department of Health Care Services. MHC and the Local Health Department shall provide ongoing support to all MHC contracted CPSP certified Providers/Practitioners.

Non-CPSP certified Providers/Practitioners may choose to outsource CPSP services. MHC Perinatal Services Staff shall provide technical assistance to Non-CPSP Providers/Practitioners in referring members to appropriate facilities (clinics, hospitals, etc.) as necessary. Non-CPSP certified Providers/Practitioners may refer their high-risk pregnancies to MHC's Motherhood Matters Program.

For more information on how to become a DHCS certified CPSP Provider/Practitioner, call the appropriate CPSP Program Coordinator:

- Imperial (760) 482-2905
- Los Angeles (213) 639-6427
- Riverside (951) 358-5260
- Sacramento (916) 875-6171
- San Bernardino (909) 388-5751
- San Diego (619) 542-4053

Authorization

Prior authorization or approval certification for either the OB or CPSP services provided for pregnant or postpartum members [defined as up to sixty (60) days after delivery] is not required. Members may see any qualified contracted Provider/Practitioner, including their PCP, an obstetrician/gynecologist, or a nurse midwife for prenatal care. Note: members in capitated IPA/Medical Groups must obtain an obstetrical Provider/Practitioner within their IPA/Medical Group network.

Member Participation

Prior to the administration of any assessment, drug, procedure, or treatment, the member must be informed of the following:

- Potential risks or hazards which may adversely affect her or her unborn infant during pregnancy, labor, birth, or postpartum.
- Alternative therapies available to her.
- The member has a right to consent to or refuse the administration of any assessment, drug, procedure, test, or treatment. The refusal of any MHC member to participate in CPSP must be documented in the member's medical record by the Provider/Practitioner or Perinatal Support Staff offering the CPSP service. Member participation is strongly encouraged, but is voluntary.

Perinatal Support Staff as defined in this document includes:

- Certified Nurse Midwives
- Registered Nurse Practitioners (Family and/or Pediatric)
- Physician Assistants
- Registered Nurses
- Social Workers
- Psychologist
- Dietitians
- Health Educators
- Child Birth Educators
- Comprehensive Perinatal Health Workers (CPHW)
- Medical Groups
- Medical Clinics
- Hospitals
- Birthing Centers
- Case Manager

PREVENTIVE CARE

MHC requires contracted Providers/Practitioners of Perinatal Services to adhere at minimum to the current American College of Obstetrics and Gynecologists (ACOG) Standards, current edition.

MHC Prenatal Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the ACOG, U.S. Preventive Services Task Force, the American Academy of Family Physicians, and others. They are updated annually. The Prenatal PHG is available on the MHC webpage at www.MolinaHealthcare.com.

Perinatal Services Available to Members and Providers/Practitioners

The MHC UM Department shall be responsible for reviewing all referrals and treatment authorization requests for Perinatal Services of MHC members where prior authorization is required. Please refer to MHC’s Prior Authorization Guide in the Healthcare Service Section.

Frequency Scheduling of Perinatal Visits/Re-Assessments

MHC Providers/Practitioners shall follow ACOG’s Guidelines for Perinatal Care regarding the frequency of visits/reassessments: Uncomplicated Pregnancy

- Every four (4) weeks for the first twenty eight (28) weeks
- Every two (2) to three (3) weeks until the thirty sixth (36th) week
- After the thirty sixth (36th) week, then weekly until delivery
- Postpartum, three (3) to eight (8) weeks after delivery

Complicated/High-risk Pregnancy

- Frequency as determined by the member’s Provider/Practitioner or Perinatal Support Staff according to the nature and severity of the pregnant member identified risk(s)
- Women with medical or obstetrical risks may require closer surveillance than the ACOG recommendations

Biochemical Lab Studies

The Perinatal Support Staff shall ensure the following biochemical lab studies are completed as part of the member's initial risk assessment:

- Urinalysis, including microscopic examination and infection screen
- Hemoglobin/Hematocrit
- Complete Blood Count
- Blood Group, ABO and RH type
- Antibody screen
- Rubella antibody titer
- Syphilis screen (VDRL/RPR)
- Gonorrhea culture
- Chlamydia culture
- Urinary Ketones
- Serum Albumin
- Hepatitis B virus screen
- Cervical Cytology
- Tuberculosis testing
- Hemoglobin electrophoresis
- Blood volume
- One hour glucose screen
- Screening for Genetic Disorders

The Perinatal Support Staff shall ensure all pregnant members who have a history of one (1) or more of the following shall have genetic disorder screening performed as part of the member's initial risk assessment and are referred to a genetic counseling center or genetic specialist, as appropriate:

- Advanced maternal age (35 years of age or older)
- Previous offspring with chromosomal aberration
- Chromosomal abnormality in either parent
- Family history of a sex-linked condition
- Inborn errors of metabolism
- Neural tube defects
- Hemoglobinopathies
- Ancestry indicating risk for Tay-Sachs, Phenylketonia (PKU), Alpha or Beta Thalassemia, Sickle Cell Anemia, and Galactosemia

The Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment and document in the member's Individualized Care Plan. Upon the Provider/Practitioner's recommendations and member consent, the appropriate procedure(s) shall be performed (i.e. amniocentesis). The Provider/Practitioner shall give results of procedure(s) to the member. Appropriate follow-up intervention shall occur, as necessary

INITIAL COMBINED PRENATAL RISK ASSESSMENT/REASSESSMENT OF THE PREGNANT MEMBER OVERVIEW

The Initial Combined Prenatal Risk Assessment/Re-Assessment is a combined risk assessment which includes medical/obstetrical, psychosocial, nutritional, and health educational components.

Perinatal Support Staff Responsibilities

Perinatal Support Staff shall be responsible for assessing and evaluating the following:

- Member's Prenatal Assessment Profile.
- Women's Food Frequency Questionnaire.
- Prenatal Weight Gain Grid - Nutritional Assessment.
- Psychosocial and Health Education assessment of the pregnant member.
- Individualized Care Plan, as appropriate, utilizing the following initial prenatal assessment tools.
- Perinatal Support Staff shall report all relevant information obtained during their assessments/reassessments to the Provider/Practitioner and document in the member's record.
- Prenatal Assessment Profile shall be available in threshold language for the specific geographic areas of membership.
- Perinatal Support Staff shall be available to assist member in completion of Prenatal Assessment Profile if member is unable to complete independently.
- Perinatal Support Staff signature shall be required if assistance was provided to member for completion of Prenatal Assessment Profile.
- Perinatal Support Staff shall review member's response to the Prenatal Assessment Profile, identify, and discuss any responses that could indicate a potential risk.
- Perinatal Support Staff shall assign a risk status of "High, Medium, or Low" for each answer on the Prenatal Assessment Profile as determined by the member's response.
- Perinatal Support Staff must initiate appropriate interventions in response to the member's identified and assigned risk status from the Prenatal Assessment Profile

NUTRITIONAL ASSESSMENT/REASSESSMENT – WOMEN'S FOOD FREQUENCY QUESTIONNAIRE

- Re-caps the member's food intake for the prior twenty four (24) hours to determine pregnant member's current nutritional status.
- Women's Food Frequency Questionnaire shall be available in threshold languages for the specific geographic areas of membership. Perinatal Support Staff shall be available to assist member in completion of Women's Food Frequency Questionnaire if member is unable to complete independently.
- Perinatal Support Staff shall review member's response to the Women's Food Frequency Questionnaire and discuss any responses that could indicate a barrier to adequate nutritional intake (i.e. alcohol/tobacco or drug use; infant feeding problems; or socioeconomic factors potentially affecting dietary intake). Member will be evaluated for the WIC Program, Food Stamps, etc. Member must be referred to the WIC Program within four (4) weeks of the first prenatal visit. The Perinatal Support Staff shall initiate

appropriate interventions in response to the member's identified nutritional risk status. The Perinatal Support Staff shall utilize relevant information obtained from the Women's Food Frequency Questionnaire to assist in the development of the member's Individualized Care Plan.

ANTHROPOMETRIC ASSESSMENT - PRENATAL WEIGHT GAIN GRID

- The Perinatal Support Staff shall obtain the member's weight (in pounds) at the initial prenatal assessment and plot on the DHCS-approved Prenatal Weight Gain Grid.
- The Perinatal Support Staff shall obtain a new weight at each perinatal assessment and plot accordingly on the Prenatal Weight Gain Grid. The Perinatal Support Staff shall compare the current weight and the total amount gained with the gain expected for the member. The Perinatal Support Staff shall consider the results of weight assessment and results of the dietary and clinical assessments to determine appropriate nutritional interventions.
- The Perinatal Support Staff shall initiate appropriate interventions in response to the member's identified risk status regarding weight.

PSYCHOSOCIAL ASSESSMENT/RE-ASSESSMENT

The Perinatal Support Staff shall be responsible for the Psychosocial Assessment/Re-assessment which includes:

- Current living status
- Personal adjustment and acceptance of pregnancy (e.g. "Is this a wanted or unwanted pregnancy?")
- Substance use/abuse
- Member's goals for herself in this pregnancy
- Member's education, employment, and financial material resources
- Relevant information from the medical history, including physical, emotional, or mental disabilities
- Experience within the health care delivery system and/or any prior pregnancy

HEALTH EDUCATION ASSESSMENT/REASSESSMENT

The Perinatal Support Staff shall be responsible for the Health Education Assessment/Re-Assessment which includes:

- Member and family/support person(s) available to member
- Motivation to participate in health education plans
- Disabilities which may affect learning
- Member's expressed learning needs and identified learning needs related to diagnostic impressions, problems, and risk factors
- Primary languages spoken and written
- Education and current reading level
- Current health practices (i.e. member's religious/cultural influences potentially affecting the member's perinatal health)
- Evaluation of mobility and residency. Transportation assistance shall be considered when

the resources immediately available to the maternal, fetal, or neonate member are not adequate to deal with the actual or anticipated condition

- Evaluation for level of postpartum self-care, infant care to include immunizations and car seat safety

Provider/Practitioner's Responsibilities

Provider/Practitioner shall be responsible for the completion of the medical/obstetrical assessment portion of the initial combined prenatal risk assessment of the pregnant member and may utilize any of the following perinatal assessment forms:

- POPRAS
- Hollister
- ACOG

A copy of the Provider/Practitioner's completed perinatal assessment form, (POPRAS, Hollister or ACOG), **must** be forwarded to the hospital identified for member's delivery by the member's thirty fifth (35th) week of gestation. Provider/Practitioner shall direct members with identified risks to hospitals with advanced obstetrical and neonatal units. Provider/Practitioner's Medical/Obstetrical Assessment includes:

- History of previous cesarean sections
- Operations on the uterus or cervix
- History of premature onset of labor
- History of spontaneous or induced abortion
- Newborn size; small or large for gestational age
- Multiple gestation
- Neonatal morbidity
- Fetal or neonatal death
- Cardiovascular disease
- Urinary tract disorders
- Metabolic or endocrine disease
- Chronic pulmonary disease
- Neurological disorder
- Psychological illness
- Sexually transmitted diseases
- Identification of medication taken which may influence/affect health status
- HIV/AIDS Risk assessment/testing and counseling (Senate Bill 899) must be offered to all pregnant members at initial prenatal assessment. Documentation in member's medical record must include that assessment, testing, and counseling was offered.
- Documentation must include if member "accepted" or "refused" risk assessment, testing, or counseling
- Blood Pressure

Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment phase. This includes health education, nutrition, and psychosocial assessment, and document in the member's Individualized Care Plan, accordingly.

Perinatal Support Staff Responsibilities Second (2nd) and Third (3rd) Trimester Re-assessments of the Pregnant Member:

- Perinatal Support Staff shall utilize the Combined second (2nd) and third (3rd) Trimester Re-Assessment Forms to ensure a continuous, comprehensive assessment of the member's status in each trimester and shall update the member's Individualized Care Plan, accordingly
- Anthropometric Assessment - Prenatal Weight Gain Grid.
- Perinatal Support Staff shall obtain the member's weight (in pounds) at each trimester
- Reassessment and plot on the Prenatal Weight Gain Grid.
- Perinatal Support Staff shall compare the total amount gained since the prior assessment against the weight gain expected for the member.
- Perinatal Support Staff shall consider the results of weight assessment and dietary and clinical assessments to determine appropriate nutritional interventions.

Provider/Practitioner's Responsibilities - Second (2nd) and Third (3rd) Trimester Reassessment of the Pregnant Member

- During the second (2nd) and third (3rd) trimester re-assessment phase, the Provider/Practitioner shall be responsible to update the POPRAS, Hollister, or ACOG form, to ensure the continuous, comprehensive assessment of the member's medical/obstetrical health status.
- The POPRAS, Hollister, or ACOG form was initiated by the Provider/Practitioner at the initial combined risk assessment phase and the same medical/obstetrical assessment form shall be utilized throughout the member's second (2nd) and third (3rd) trimester reassessment phases.
- The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the Provider/Practitioner completed the previous assessment; the information obtained by the Provider/Practitioner shall be utilized to update the member's Individualized Care Plan, accordingly.

Provider/Practitioner's medical/obstetrical assessment of the member's health status shall include, but not be limited to:

- Blood pressure, weight, uterine size, fetal heart rate, presence of any edema, and Leopold's maneuvers.
- After quickening, the Provider/Practitioner shall inquire and instruct member on completing fetal kick count after twenty eight (28) weeks gestation.
- Education and counseling on signs and symptoms of preterm labor and appropriate actions to take.
- Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the member's trimester re-assessment phase and document in the member's Individualized Care Plan, accordingly.

COMBINED POSTPARTUM ASSESSMENT FOR THE MEMBER

Provider/Practitioner's Responsibilities Postpartum Phase

- Provider/Practitioner's postpartum assessment should occur within twenty-one (21) to

fifty-six (56) days post-delivery. Time frames for postpartum assessment may be modified if warranted by the specific needs of the postpartum member.

- Postpartum access two (2) weeks post C-section falls outside of this requirement.
- Provider/Practitioner shall be responsible for assessing the member's current medical/obstetrical health status by referencing the POPRAS, Hollister, or ACOG form which was initiated by the Provider/Practitioner at the initial prenatal risk assessment phase and updated with assessment information obtained during the second (2nd) and third (3rd) trimester re-assessment phases to ensure a continuous assessment of the postpartum member. The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the previous member assessment;
- Information obtained by the Provider/Practitioner shall be utilized to update the member's Individualized Care Plan accordingly.
- Provider/Practitioner must initiate appropriate interventions in response to any problems/risks/needs identified during the member's postpartum phase and document in the member's Individualized Care Plan, accordingly.

Perinatal Support Staff Responsibilities - Postpartum Phase [three (3) to eight (8) weeks after delivery]

- Perinatal Support Staff shall utilize the Combined Postpartum Assessment Form to provide for a comprehensive assessment of the postpartum member in the following areas and update the member's Individualized Care Plan.
- Anthropometric Assessment - Prenatal Weight Gain Grid. Perinatal Support Staff shall obtain the member's postpartum weight (in pounds) and plot on the Prenatal Weight Gain Grid. Perinatal Support Staff shall consider the results of the weight, dietary, and clinical assessments to determine the appropriate nutritional interventions.
- Nutritional Assessment - Women's Food Frequency Questionnaire. Member shall complete the Women's Food Frequency Questionnaire that re-caps the food intake for the prior twenty four (24) hours to determine nutritional status and any potential economic barriers to adequate nutrition for the member and infant. Member to be evaluated for the WIC Program, Food Stamps, etc. Perinatal Support Staff shall counsel breast-feeding mothers on dietary needs of breast-feeding and management of specific breast-feeding problems i.e. address member's individual concerns and needs, refer high-risk members for appropriate intervention.

Health Education Assessment

- Perinatal Support Staff shall evaluate the member's level of health education regarding postpartum self-care and infant care and safety to include car seat, immunizations, breast-feeding, and well-child care (CHDP). Perinatal Support Staff shall identify those health education behaviors, which could promote risk to the postpartum member or the infant.
- Perinatal Support Staff shall discuss and counsel the postpartum member on smoking cessation, substance and alcohol use, family planning and birth control methods, and provide information on Family Planning Centers, as appropriate.
- Perinatal Support Staff shall identify goals to be achieved via health education interventions.

- Perinatal Support Staff to discuss importance of referral of infant for CHDP exam, immunizations, and well-child care.
- Perinatal Support Staff shall educate the member on how to enroll the newborn in the Plan and how to select a PCP for the newborn.

Psychosocial Assessment

- Perinatal Support Staff shall identify psychosocial behaviors which could promote a risk to the postpartum member or the infant.
- Perinatal Support Staff shall identify and support any strengths and habits oriented towards optimal psychosocial health.
- Perinatal Support Staff shall identify goals to be achieved via psychosocial interventions.
- Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified in the member's postpartum phase and document in the member's Individualized Care Plan, accordingly.

Complicated/High-risk Pregnancy - Identification and Interventions

- Early identification of complicated/high-risk pregnancy is critical to minimizing maternal and neonatal morbidity.
- Both Providers/Practitioners and Perinatal Support Staff shall be responsible for identifying the complicated/high-risk pregnancy and providing the appropriate intervention(s).
- Referrals to physician specialists; i.e. Perinatal Specialist, Neonatal Specialist.
- Coordinating with other appropriate medically necessary services.
- Coordinating with appropriate support services/agencies.
- Referrals to the Local Health Department support agencies.
- Coordinating with MHC Perinatal Services Staff for appropriate interventions and follow-up.
- Coordinating with MHC Medical Case Manager for appropriate interventions and follow-up through the Case Coordination/Management process of Perinatal Services.

Individualized Care Plans (ICPs)

- All pregnant members, regardless of risk status, must have an ICP.
- ICPs must be initiated at first prenatal visit.
- ICPs must be reviewed and revised accordingly, each trimester at the minimum, throughout the pregnancy and postpartum phases, by the Provider/Practitioner and the Perinatal Support Staff members.

ICPs must address/document the following four (4) components:

- Nutritional Assessment
- Psychosocial Assessment
- Health Education Assessment
- Medical/Obstetrical Health Status Assessment

ICPs documentation within the four (4) component areas must address the following:

- Nutritional Assessment: Prevention and/or resolution of nutritional problems. Support and maintenance of strengths and habits oriented toward optimal nutritional status and goals to be achieved via nutritional interventions.

- Psychosocial Assessment: Prevention and/or resolution of psychosocial problems.
- Support and maintenance of strengths in psychosocial functioning and goals to be achieved via psychosocial interventions.
- Health Education Assessment: Health education strengths, prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk reduction behaviors, goals to be achieved via health education interventions and health education interventions based on identified needs, interests, and capabilities.
- Medical/Obstetrical Health Status Assessment: Continuous evaluation of the member's medical and obstetrical health status.

ICPs must be developed from multidisciplinary information obtained and interventions initiated resulting from, but not limited to, the following:

- Prenatal Assessment profile;
- Women's Food Frequency Questionnaire;
- Prenatal Weight Gain Grid;
- Providers/Practitioners assessment to include Medical/Obstetrical Health status;
- Providers/Practitioners second (2nd) and third (3rd) Trimester re-assessment to include Medical/Obstetrical Health status; and
- Perinatal Support Staff's individualized review of member and their Psychosocial, Health Education, and Nutritional Assessment results.

ICPs shall serve as an effective tool for the ongoing coordination and dissemination of information on the pregnant member's perinatal care throughout all phases of the pregnancy and postpartum (i.e. initial visit, all trimester reassessments and postpartum). For any of the multidisciplinary Perinatal Support Staff or Provider/Practitioner involved with the member, ICPs shall serve as an identification source/summary of prioritized problems, needs, or risk conditions as identified.

- ICPs must be created and individualized for each pregnant member.
- ICPs must be created in conjunction with the pregnant member.
- ICP must clearly define who is responsible for implementing the proposed interventions and the timeframes.

MOTHERHOOD MATTERS PREGNANCY PROGRAM

Motherhood Matters Pregnancy Program encompasses clinical case management, member outreach, and member and Provider/Practitioner education. The Perinatal Case Management staff works closely with the Provider/Practitioner community in the identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program comprises multi-departmental activities to ensure the coordination and delivery of comprehensive services to participating members. The main focus of the program is on member outreach to identify pregnant women and the subsequent provision of risk assessment, education, and case management services. Members receive incentives for participating in the program.

Motherhood Matters program does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to the

members. **For members who are receiving CPSP services at the time of entry into Motherhood Matters, the program will serve as back-up and additional support resource.**

The goals of pregnancy management program are to:

- Improve MHC knowledge of newly pregnant members, or members newly accessing prenatal care.
- Identify all pregnant members as early as possible in the course of their pregnancy.
- Improve the rate of screening pregnant members for potential risk factors by the administration of initial and subsequent assessments.
- Provide education services to all pregnant members and their families.
- Refer members at high-risk for poor pregnancy outcome to perinatal case management
- Provide coordinated, integrated, continuous care across a variety of settings.
- Actively involve Providers/Practitioners, members, families, and other care providers in the planning, provision, and evaluation of care.
- Meet patients', families' and Providers/Practitioners' expectations with pregnancy care.
- Improve the quality of information collection and statistical analysis; in order to assess the effectiveness of the program and to project future needs.
- Monitor program effectiveness through the evaluation of outcomes.

Eligibility Criteria for Program Participation and Referral Source

Motherhood Matters is a population based pregnancy program, which includes all pregnant females of any age. To participate in the program, the member is Medi-Cal eligible and enrolled with MHC and resides in San Bernardino, Riverside, Sacramento, or San Diego Counties.

Referral Source

Potential participants may be identified from a number of sources including, but not limited to:

- Physician referral (Pregnancy Notification Report Form (“PNR” Form)
Providers/Practitioners are required to notify MHC within seven (7) days of a positive pregnancy test by completing the PNR form and faxing toll free to (855) 556-1424. If you have any questions or need assistance, please call (877) 665-4628.
- Members self-referral
- Member Services (as a result of member outreach calls)
- Utilization Management (as a result of authorization requests or triage service calls)
- Quality Improvement (as a result of various reports submitted monthly by IPAs/Medical Groups)
- Pharmacy utilization data (prenatal vitamin prescriptions)
- Nurse Advice Line referrals
- Laboratory Data

Program Components

1. Assessment and Referral

Following an initial health assessment performed by the Motherhood Matters Coordinator, the risk factors are scored and based on the assessment outcome pregnant members are risk-stratified into two levels:

- I. Normal pregnancy - No identified risks
- II. High risk pregnancy - Risk factors identified

Perinatal Case Management staff reviews all level II members for actual or potential at risk pregnancy. High-risk indicators include, but are not limited to:

- Age under 18 or over 35
- Unstable or high-risk social situation (inadequate shelter or nutrition; abuse)
- History of prior cesarean section
- Current or past gestational diabetes or other medical co-morbidity
- History of repeated spontaneous abortion
- History of preterm labor or premature birth
- History of fetal demise, stillbirth, or other poor pregnancy outcome
- Smoking, alcohol, drug, or other substance abuse
- History of behavioral health problems

Members who are positive for any of the above indicators, or have other indications as determined, remain in prenatal case management for detailed assessment and further evaluation and intervention(s), as appropriate. Regardless of the type or absence of identified risk, all pregnant members are provided pregnancy related education services.

Following the completion of initial assessment, subsequent trimester specific assessments are conducted throughout the pregnancy. A postpartum assessment is completed one (1) to five (5) weeks after the delivery.

2. Health Education

The Motherhood Matters coordinators mail educational materials after initial assessment. Special materials are provided to teenagers and those assessed as non-English readers. All program participant mailings are documented in the appropriate medical management system. For those participants with identified risks that can be addressed through educational intervention, additional member education services may be provided by a health educator and/or social worker within the Care Management team. Participants identified with nutritional risk, may also include a comprehensive nutrition assessment and the development of a meal plan by a Registered Dietitian.

3. High-risk Case Management

The case management of high-risk pregnancy incorporates an intensive process of case assessment, planning, implementation, coordination, and evaluation of services required to facilitate an individual with high-risk obstetrical conditions through the health care continuum. The program consists of a comprehensive approach toward evaluating the member's overall care plan through an assessment and treatment planning process. The case management process comprises case triage and collaboration with treating physician(s), ancillary and other Providers/Practitioners, and development of an individual care plan.

Perinatal case management registered nurses, in conjunction with the treating physician, coordinate all health care services. This includes the facilitation of appropriate specialty care referrals, coordination of home health and DME service, and referral to support groups/social services within the member's community. MHC's case managers work closely with Public Health Programs to ensure timely and appropriate utilization of available services (e.g. WIC) and may include California Children's Services for members under age 21. Additionally, case

managers coordinate services with the Comprehensive Perinatal Services Program in cases where the member is already receiving such services.

To ensure timely follow-up with the Provider/Practitioner, the database supporting the program has the capability to generate reminders for call backs for trimester specific assessments, prenatal visits, postpartum visits, and well-baby checkups.

4. Provider Education

To ensure consistency in the approach of treating high-risk pregnancy, MHC has developed clinical guidelines and pathways, with significant input from practicing obstetricians. While the guidelines originate from nationally recognized sources, their purpose is to serve as a starting point for Providers/Practitioners participating in health management systems program. They are meant to be adapted to meet the needs of members with high-risk pregnancies, and to be further refined for individual patients, as appropriate. The guidelines are distributed to MHC network participating obstetrical Providers/Practitioners. Other methods of distribution and updating are via *Just the Fax* weekly electronic publications, continuing medical education programs, quarterly physician newsletter, and individual Provider/Practitioner contact.

New Member Outreach

Information introducing MHC's Motherhood Matters Perinatal Services Program, that emphasizes early entry into the program, is included in MHC's Welcome Package.

- The Welcome Package shall be mailed to all new MHC members or responsible party within seven (7) days of enrollment.
- Annually updated Evidence of Coverage shall be mailed to all MHC members or responsible party.
- Enrollment Counselors inquire if any members of the household are pregnant during the new Member outreach call. Pregnant women are referred directly to the Motherhood Matters Program staff.
- The Welcome Package shall be printed and distributed in appropriate threshold languages for MHC members.

Focused Reviews/Studies

All compliance monitoring and oversight activities are undertaken with the goal of assisting and enabling the perinatal Provider/Practitioner to provide care and services that meet or exceed community/professional standards, Department of Health Care Services (DHCS) contractual requirements, and National Committee for Quality Assurance (NCQA) standards and that health care delivery is continuously and measurably improved in both the inpatient and outpatient/ambulatory care setting.

Obstetricians with five (5) or more deliveries require a Prenatal/OB medical record review once every three (3) years. The performance goal is 85% or above for the following categories: Format and documentation; OB/CPSOP Guidelines (Perinatal Preventive Criteria); and Continuity and Coordination of Care. Audit results are reported to the Quality Improvement Committee.

Grievances and Survey

- The QI Department utilizes Provider/Practitioner and member surveys to assess compliance with Plan standards.

- The QI Department investigates, monitors, and provides follow-up to Provider/Practitioner and member grievances involving potential clinical quality issues.

Findings are reported to the individual Provider/Practitioner, the Clinical Quality Management Committee, the Quality Improvement Committee, and/or the Credentials Committee as appropriate.

NURSE MIDWIFE SERVICES

Defined by Title 22, nurse midwife services are permitted under state law and are covered when provided by a Certified Nurse Midwife (CNM). MHC will provide access to and reimbursement for CNM services under state law. Federal guidelines have been established and members have the right to access CNM services on a self-referral basis.

Covered Services

All eligible MHC members are eligible to receive the following limited care and services from a CNM:

- Mothers and newborns through the maternity cycle of pregnancy
- Labor
- Birth
- Immediate postpartum period, not to exceed six (6) weeks

The CNM services must be provided within seven (7) calendar days of request, based on the severity of the member's condition.

Procedure

Referral to a contracted CNM may be made by either a Primary Care Practitioner (PCP) or by the member requesting the services.

- Minors may access a CNM in accordance with MHC Policy and Procedure, Confidential Access to Service for Minors, or applicable policy.
- The CNM will work under the direction of a supervising Provider/Practitioner as defined by law.

Notification

Members are notified of the availability of CNM services through their PCP or OB/GYN Providers/Practitioners. Members are also notified of availability of services through the Evidence of Coverage, which is distributed at the time of enrollment and annually thereafter.

Supervising Providers/Practitioners

Supervising Providers/Practitioners will submit claims directly to MHC, in accordance with MHC's Claim Payment Policy and Procedures. This instruction also addresses the appeal process for denial of claims (Please reference to Claims Manual).

The CNM will be credentialed through the credentialing and re-credentialing process of allied health Providers/Practitioners at MHC or subcontracted affiliated plan.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

The Women, Infants & Children (WIC) Supplemental Food Program provides an evaluation and, if appropriate, a referral for pregnant, breast-feeding, or postpartum women or parents or guardians of a child under 5 years of age. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under 5 years of age with a medical/nutritional need.

Program Services

WIC participants receive a packet of food vouchers each month, which they can redeem at the local retail market of their choice, for supplemental food such as milk, eggs, cheese, cereal, and juice. WIC participants attend monthly nutrition and health education classes and receive individual nutrition counseling from registered dietitians and nutrition program assistance. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breast-feeding.

Policy

As part of the initial evaluation, Provider/Practitioners will document the referral of pregnant, breast-feeding, or postpartum women or a parent/guardian of a child under age 5 to the WIC program. Evidence of the referral will be documented in the member's medical record. Children will be screened for nutritional problems at each initial, routine, and periodic examination. Children and women, who are pregnant, postpartum, and breast-feeding, will be referred to the local WIC supplemental-food program. Follow-up of WIC referrals will be completed and documented at each subsequent periodic visit.

Identifying Eligible Members

Members are eligible for WIC services if they meet one (1) of the following criteria:

- Pregnant woman
- Breast-feeding woman (up to one (1) year after childbirth)
- Postpartum woman (up to six (6) months after childbirth)
- Child under age 5 years who is determined to be at nutritional risk by a health professional

To maintain eligibility, members must also:

- Receive regular medical checkups
- Meet income guidelines
- Reside in a local agency service area

Referrals to WIC

PCPs are responsible for referring eligible members to WIC programs, providing required documentation with each referral, and coordinating follow-up care. Upon request of the PCP, MHC will assist in the coordination of the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals to WIC services must be made on one (1) of the following forms:

- PM-160, CHDP Form
- PM-247, WIC Pediatric Referral Form
- PM-247A, WIC Referral for Pregnant Women Form
- Nutritional Questionnaire
- Provider/Practitioner Prescription Pad

Federal WIC regulations require hemoglobin or hematocrit test values at initial enrollment and when participants are re-certified. These biochemical values are used to assess eligibility for WIC program benefits. Children will be referred to WIC for the following conditions:

- Anemia - Please refer to the Pediatric and Child Health Services Section of this Manual for details.
- Abnormal growth (underweight, overweight)
- Underweight is defined as being in the fifth (5th) percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics.
- Overweight is defined as being over the one hundred twentieth (120th) percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics.

Women who are pregnant, postpartum, and/or breast-feeding will be referred to WIC according to the MHC perinatal protocols located in the Women's and Adult Health Services Including Preventive Care Section of this Manual.

Blood tests will be conducted not more than sixty (60) days prior to WIC certification and be pertinent to the category for enrollment. The following data will be collected:

- Data for persons certified as pregnant women will be collected during their pregnancy.
- Data for postpartum and breast-feeding women will be collected after the termination of pregnancy.

The biochemical values that are required at each certification include: WOMEN - PERINATAL, POSTPARTUM, BREAST-FEEDING:

- Hemoglobin or hematocrit values are required at each certification including:
- Initial prenatal enrollment.
- Postpartum certification - up to six (6) weeks after delivery.
- Certification of breast-feeding women - approximately six (6) months after delivery.
- Hemoglobin or hematocrit values are required at initial enrollment and with each subsequent certification approximately every six (6) months. Biochemical data is not required when:
- An infant is six (6) months of age or under at the time of certification.
- A child over one (1) year had blood values within normal limits at the previous certification. In this case, the hemoglobin and hematocrit (H&H) is required every twelve (12) months.

Assessments

All WIC eligible members will have a nutritional assessment completed at the time of the initial visit by the PCP. Children will be screened using the following tools to assess nutritional status:

- Nutritional assessment history form

- Physical examination of height/weight
- Laboratory screening of hemoglobin or hematocrit
- Laboratory screening of blood lead levels

Nutritional education will be done by the PCP and documented in the member's medical record. The MHC Provider Services Department will inform Providers/Practitioners of the Federal WIC anthropometric and biochemical requirements for program eligibility, enrollment, and certification.

Providers/Practitioners will complete the WIC Medical Justification Form for members requiring non-contract special formula and state the diagnosis and expected duration of the request for the special formula. Provider/Practitioners will provide a copy of the member's health assessment, including nutritional risk assessment, to the local WIC office after the member's consent has been received to release this information.

Medical Documentation

It is essential that Providers/Practitioners document WIC referrals in the member's medical records. The documentation can be a copy of the referral form and/or notes in the member's file documenting the visit and subsequent referrals. WIC considers findings and recommendations of referrals to be confidential and declines to share information regarding individual referral findings. WIC has agreed to share aggregate data pending clarification regarding confidentiality from the Department of Agriculture. Until clarification is made, the PCP should encourage members to inform him/her of the outcome of their WIC visit, thereby allowing the PCP to provide appropriate and consistent follow-up, noting outcomes in the progress notes of the member's medical record.

Local Health Department Coordination

The WIC offices, through the Local Health Department, will function as a resource to MHC and Providers/Practitioners regarding WIC policies and guidelines, program locations, and hours of operation.

BREAST-FEEDING PROMOTION, EDUCATION, AND COUNSELING SERVICES

Primary Care Providers/Practitioners, Pediatric Providers/Practitioners, and Ob-Gyn Providers/Practitioners must provide postnatal support to postpartum breast-feeding mothers through continued health education, counseling, and the provision of medically necessary interventions such as lactation durable medical equipment.

Postpartum women should receive the necessary breast-feeding counseling and support immediately after delivery. Assessment of breast-feeding support needs should be part of the first newborn visit after delivery.

MHC endorses the following statement by the American Academy of Pediatrics, that "breast-feeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant" (AAP Policy Statement, 2005). The vast benefits of breast-feeding for

the infant, mother and the community have been well researched and documented. They include nutritional, developmental, immunological, psychosocial, economic and environmental benefits. It is recognized that there may be some barriers to breast-feeding due to physical or medical problems with the mother or infant, poor breast-feeding technique, or complementary feeding. All postpartum women should be offered breast-feeding resources to help them make informed choices about how to feed their babies and to get the information and support they need to breastfeed successfully. The distribution of promotional materials containing formula company logos is prohibited as per MMCD policy letter 98-10.

Pregnant members should be referred to MHC's Motherhood Matters Pregnancy Program. MHC Health Education Assistants conduct postpartum assessments and health education to members referred to the Motherhood Matters Pregnancy Program. Breast-feeding promotion and counseling are included in third trimester assessment and the postpartum health assessment conducted as part of the program. Members can also be referred to lactation counselors through local WIC offices. For breast-feeding education materials to support breast-feeding members, please contact the Health Education Department at (866) 472-9483.

Durable Medical Equipment

Lactation management aids, classified as Durable Medical Equipment (DME), are covered benefits for MHC members. Specialized equipment, such as electric breast pumps, will be provided to breast-feeding MHC members when medically necessary.

Human Milk Bank

Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. The provision of human milk for newborns will be arranged in the following situations:

- Mother is unable to breastfeed due to medical reasons and the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas.

For information regarding human milk banks, please contact your local WIC office.

ADULT PREVENTIVE CARE SERVICES GUIDELINES

MHC implements programs to encourage preventive health behaviors which can ultimately improve quality outcomes. Preventive Health Guidelines (PHG) are updated annually and derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. The recommended services noted in the Preventive Health and Clinical Practice Guidelines are based on clinical evidence; however, Providers/Practitioners and members should check with the Plan to determine if a particular service is a covered benefit.

- Preventive Health Guidelines: see website (www.MolinaHealthcare.com) for current and updated guidelines.
- Clinical Practice Guidelines: see website (www.MolinaHealthcare.com) for current and updated guidelines.

To request a hardcopy of the guideline, contact MHC's Provider Services at (888) 665-4621.

INITIAL HEALTH ASSESSMENTS (IHA)

The Primary Care Physician (PCP) has the principal role to maintain and manage his/her assigned members. The PCP conducts the Initial Health Assessment and provides necessary care to assigned members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the member's initial encounter with a selected or assigned PCP and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member.

The Department of Health Care Services recently updated the Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA) assessment tools. All assessment questions were updated in accordance with the guidelines of the US Preventive Services Task Force and other relevant governmental and professional associations. The DHCS and MHC require providers to administer an IHEBA to all Medi-Cal managed care patients as part of their IHA and well care visits. **Members are required to have an IHA within 120 days of enrollment with the plan.**

The goals of the SHA are to assist providers with:

- Identifying and tracking high-risk behaviors of members.
- Prioritizing each member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

IHA Overview & PCP Responsibilities

- All members must have a complete IHA within 120 calendar days of enrollment.
- This assessment should be done on the member's initial visit, will be both gender and age specific, and include a history and physical examination.
- The IHA for members under age 21 will be based on American Academy of Pediatrics (AAP) guidelines and will include the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP). These preventive visits must include age specific assessments and services required by the Child Health and Disability Prevention Program (CHDP).
- The IHA for members over age 21 will meet the guidelines addressed in U.S. Preventive Services Task Force (USPSTF) and recommendations delineated in MHC's Preventive Health and Clinical Practice Guidelines.
- The IHA must be accompanied by an initial health education behavioral assessment, utilizing the MMCD developed "Staying Healthy" Assessment tool.
- PCPs are responsible for reviewing each member's SHA in combination with the following relevant information: Medical history, conditions, problems, medical/testing results, and member concerns; Social history, including member's demographic data, personal circumstances, family composition, member resources, and social support; and Local demographic and epidemiologic factors that influence risk status.
- The PCP must review the assessment, provide needed counseling or other intervention, document on the assessment, and file in the member's medical record with other

continuity of care forms. The age-appropriate questionnaire must be reviewed with the member and/or parent at least annually. Multi-lingual and age appropriate Staying Healthy assessment forms are available on the MHC website and on the DHCS website. Please refer to the below link to access this

information: www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

- The SHA is an age-appropriate questionnaire that must be administered during the member’s IHA (within 120 days of the effective date of enrollment) and again at defined age intervals. Current members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table below.
- It is recommended that page two (2) of the completed “Staying Healthy” Assessments for age 12-17 should be placed under the “sensitive tab” in the medical record, preventing photocopying should a parent/guardian request the record. This precaution protects the confidentiality of the minor’s disclosures, according to the MMCD letter 99-07, Individual Health Behavioral Assessment.

The SHA Periodicity Table and SHA administration policy is summarized in the below table:

Periodicity	Initial SHA Administration	Subsequent SHA Administration / Re-Administration		SHA Review
Age Groups	Within 120 Days of Enrollment	1 st Scheduled Exam (after entering new age group)	Every 3-5 years	Annually (Intervening years between administration of new assessment)
0-6 mo.	✓			
7-12 mo.	✓	✓		
1-2 yrs.	✓	✓		✓
3-4 yrs.	✓	✓		✓
5-8 yrs.	✓	✓		✓
9-11 yrs.	✓	✓		✓
12-17 yrs.	✓	✓		✓
Adult	✓		✓	✓
Senior	✓		✓	✓

- Members must be informed that they may refuse to respond to any question or refuse to complete the entire IHA. Refusal must be documented in the member’s medical record. This may be done by noting on the assessment itself, signing, dating, and filing it in the medical record. When a member refuses the IHA, the PCP must inform the member of the benefits, risks, and suggest alternatives. The PCP must document such discussion and advice in the member’s medical record.
- The results of the IHA must be documented by PCP in the Progress Notes section of the member’s medical record. The PCP may utilize an initial history and physical form that is specific to his/her practice. In the event that specific forms do not address all recommended areas, those findings are to be addressed in the Progress Notes section of the member’s medical record
- Perinatal Care Providers who cares for MHC members during pregnancy may provide the

IHA through initial perinatal visit(s), and must document that the prenatal visit(s) met IHA content and timeline requirements.

- MHC will provide you with resources to assist you with implementation of IHA. Contact your MHC Provider Services Representative or MHC's Health Education Department at (800) 526-8196 with your request on "Staying Healthy" Assessment assistance.
- MHC contacts members within thirty (30) calendar days of enrollment to encourage scheduling an appointment for an initial health assessment. Members are informed of the benefit in the Evidence of Coverage. The requirement is waived if the member's PCP determines the member's medical record contains complete and current information consistent with the IHA requirements (such as history and physical exam that is age and gender specific, evaluates risk factors, and the socioeconomic environment of a Plan member).

Initial Health Assessment Components

IHA consist of the following:

A. Comprehensive History: must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes, but is not limited to the following:

1. History of Present Illness
2. Past Medical History
 - a. Prior major illnesses and injuries
 - b. Prior operations
 - c. Prior hospitalizations
 - d. Current medications
 - e. Allergies
 - f. Age appropriate immunization status
 - g. Age appropriate feeding and dietary status
3. Social History
 - a. Marital status and living arrangements
 - b. Current employment
 - c. Occupational history
 - d. Use of alcohol, drugs, and tobacco
 - e. Level of education
 - f. Sexual history
 - g. Any other relevant social factors
4. Review of Organ Systems

B. Preventive Services

1. Adults: referenced under IHA Overview
2. Members under 21 Years of Age: referenced under IHA Overview
3. Perinatal Services
 - a. Must provide perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG).
 - b. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.
 - c. Risks identified must be followed up with appropriate interventions and documented in the medical record.

- C. Comprehensive Physical and Mental Status Exam
- D. Diagnoses and Plan of Care
- E. Individual Health Education Behavioral Assessment (IHEBA): the age specific and age appropriate behavior risk assessment should address the following areas:
 - 1. Diet and Weight Issues
 - 2. Dental Care
 - 3. Domestic Violence
 - 4. Drugs and Alcohol
 - 5. Exercise and Sun Exposure
 - 6. Medical Care from Other Sources
 - 7. Mental Health
 - 8. Pregnancy
 - 9. Birth Control
 - 10. STIs/STDs
 - 11. Sexuality
 - 12. Safety Prevention
 - 13. Tobacco Use and Exposure

DENTAL SCREENING

MHC members are entitled to an annual dental screening described in the periodic health exam schedules. Dental services, other than dental screenings, are not covered.

A dental screening will be performed at the time of all health assessments by the Primary Care Practitioner (PCP). The screening will include, but not necessarily be limited to:

- A brief dental history
- Examination of the teeth
- Examination of the gum
- Dental education

Findings of the dental screen, including education provided to the member or family, will be documented in the member's medical record.

Referral Process

A dental referral does not require prior authorization. Each PCP office is encouraged to maintain a list of local fee-for-service Medi-Cal dentists to whom members may be referred. Members may obtain the DHCS 800 telephone number for dental referral assistance from MHC's Customer Services Department. The Denti-Cal Beneficiary line is (800) 322-6384.

Primary Care Practitioner's (PCP) Responsibility

The PCP should conduct a dental assessment to check for normal growth and development and for the absence of tooth and gum disease at the time of the initial health assessment and at each CHDP examination visit, according to the periodic health examination schedules. PCPs should perform a screening dental exam on adult members and encourage their adult patients to receive an annual dental exam.

The PCP should perform an initial dental exam referral to a Medi-Cal approved dentist when the member reaches age, 3 or earlier if dental problems are identified, and continue to refer the member annually thereafter. All referrals, and the reason for the referral, should be documented in the member's medical record.

VISION CARE SERVICES

MHC's members will receive access for covered vision care services.

Referral

Members may be referred for vision care services by their PCP or may access vision care services on a self-referral basis. A referral for a diabetic retinal exam is not required if there is a diagnosis of diabetes. Members may obtain, as a covered benefit, one (1) pair of prescription glasses every two (2) years. No prior authorization is required for receipt of this benefit through a qualified participating Provider/Practitioner. Basic member benefits include an eye examination with refractive services and prescription eyewear every two (2) years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions.

Contracted Providers/Practitioners will order the fabrication of optical lenses from the Prison Authority Optical Laboratories for members enrolled in the health plan.

MHC Providers/Practitioners are to refer members to March Vision Care for vision care services at (888) 493-4070.

Routine Eye Examination

The PCP plays a vital role in detecting ocular abnormalities that require referrals for a comprehensive eye examination.

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at approximately three (3) years of age. Children between four (4) and six (6) years of age should have a comprehensive eye examination in addition to the screening performed by the PCP. Children with prescription eyewear or contact lenses should have an eye examination annually.

Children should have a comprehensive eye examination by an ophthalmologist if they have one (1) or more of the following indications:

- *Abnormalities on the screening evaluation*
- *Recurrent or continuous signs or symptoms of eye problems*
- *Multiple health problems, systemic disease, or use of medications that are known to be associated with eye disease and vision abnormality*
- *A family history of conditions that cause, or are associated with, eye or vision problems*
- *Health and developmental problems that makes screening difficult or inaccurate.*

FAMILY-PLANNING SERVICES

Members are allowed freedom of choice in selecting and receiving family-planning services from qualified Providers/Practitioners. Members may access family-planning services from any qualified family-planning Provider/Practitioner without referral or prior authorization. Members may access family-planning services from any qualified Provider/Practitioner, including their PCP, contracted or non-contracted Provider/Practitioner, OB/GYN Providers/Practitioners, nurse midwives, nurse practitioners, nurse physician assistants, Federally Qualified Health Centers (FQHC), and local county family-planning Providers/Practitioners.

The right of members to choose a Provider/Practitioner for family-planning services will not be restricted. Members will be given sufficient information to allow them to make an informed choice, including an explanation of what family-planning services are available to them.

Family-Planning Services

Access to family-planning services will be convenient and easily comprehensible to members. Members will be educated regarding the positive impact of coordinated care on their health outcome, so members will be more likely to access services with MHC. If the member decides to see an out-of-plan Provider/Practitioner, the member will be encouraged to agree to the exchange of medical information between Providers/Practitioners for better coordination of care. The following family-planning services will be available to all members of childbearing age to prevent or delay pregnancy temporarily or permanently:

- Health education and counseling necessary to understand and to make informed choices about contraceptive methods
- Limited history and physical examination
- Medically indicated laboratory tests (except Pap smear provided by a non-contracted Provider/Practitioner where the plan has previously covered a Pap smear by a plan Provider/Practitioner within the last year)
- Diagnosis and treatment of sexually transmitted diseases
- Screening, testing, and counseling of at-risk individuals for HIV treatment
- Follow-up care for complications associated with contraceptive methods issued by the family-planning Provider/Practitioner
- Provision of contraceptive pills, devices, and supplies (including Norplant)
- Tubal Ligation
- Vasectomies
- Pregnancy testing and counseling

The following are NOT reimbursable as family-planning services:

- Routine infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only
- All abortions, including but not limited to, therapeutic abortions, spontaneous, missed, or septic abortions and related services (Note: Pregnancy testing and counseling performed by an out-of-plan family-planning Provider/Practitioner is reimbursable regardless of the member's decision to abort)
- Transportation, parking, and childcare

Provider/Practitioner Responsibilities

Providers/Practitioners may not restrict a member's access to family-planning services, nor should a Provider/Practitioner subject a member to any prior authorization process for family-planning services. Providers/Practitioners found to be non-compliant may be subject to administrative review and/or possible disciplinary action.

The family-planning Provider/Practitioner must obtain informed consent for all contraceptive methods, including sterilization.

Procedure

- Family-planning and Sexually Transmitted Disease (STD) services will be provided in a timely manner.
- Members who request an office visit for STD or family-planning services will be considered as an urgent care appointment request, requiring an appointment within twenty-four (24) hours.
- Family-planning services will be available through the PCP's office or through a referral from the PCP to a contracted specialist qualified to provide services, or to an out-of-network family-planning Provider/Practitioner.
- For services to be rendered by contracted Providers/Practitioners within the MHC network, the PCP may initiate a referral on the same day as the member presents. This referral does not require prior authorization from MHC's Utilization Management.
- For family-planning services requiring an inpatient stay, the PCP is to notify MHC's Utilization Management Department to coordinate care.
- Should a member request from the PCP a referral to a family-planning or STD Provider/Practitioner outside of MHC's contracted network, the PCP will educate the member regarding the positive impact of coordinated care on his/her health outcomes, helping the member to recognize the advantages of seeking services within MHC's network. If the member still wants to see an out-of-plan Provider/Practitioner, the member will be encouraged to agree to the exchange of medical information between Providers/Practitioners for coordination of care.
- The PCP should not refer members to non-contracted Providers/Practitioners for family-planning, STD, or HIV services; however, the member will be advised of his/her right of choice to family-planning Providers/Practitioners through the Evidence of Coverage.
- When a member presents, the PCP will evaluate the request for family-planning services and inform the member of his/her recommendations and options.

Patient Information

Members will receive information to allow them to make an informed choice including:

- Types of family-planning services available
- Right to access these services in a timely and confidential manner
- Freedom to choose a qualified family-planning Provider/Practitioner

Minors

Minors have the right to seek treatment in a confidential manner. (Refer to MHC policies, Confidential Access to Services for Minors, Collection, Use, Confidentiality, and Release of Primary Health Care Information).

Documentation

The PCP will document recommendations made and options available, the consultation and counseling provided, and the response of the member. The documentation will include any referral or recommendations.

Documentation by the Provider/Practitioner will be in compliance with MHC Policy, Medical Records Content and Documentation.

Confidentiality

- The member must give his/her consent to any Family-planning Services assessment and treatment. A signed, informed consent will be obtained when indicated by surgical or invasive procedure.
- Records are to be maintained in a confidential manner according to MHC policy, Collection, Use, Confidentiality, and Release of Primary Health Care Information.
- All information and the results of the Family-Planning Services of each member will be confidential and will not be released without the informed consent of the member.
- Appropriate governmental agencies will have access to records without consent of the member; i.e. Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Department of Health and Human Services (DHHS), Department of Justice (DOJ).

Non-Compliance

Missed Family-Planning Service appointments within the MHC network will be addressed by utilizing MHC's policy for Failed or Missed Appointments.

Non-compliance by a member will be acted upon by the PCP through MHC policy, Access to Health Care, which addresses follow-up and documentation of failed or missed appointments.

Coordination with Out-of-Plan Providers/Practitioners

Reimbursement to out-of-plan Providers/Practitioners will be provided at the applicable Medi-Cal rate appropriate to the Provider/Practitioner type, as specified in Title 22, Section 51501. Records obtained from out-of-plan Providers/Practitioners will be shared with the PCP for the purposes of assuring continuity of care. Out-of-plan Providers/Practitioners will be reimbursed for family-planning services only if:

- The out-of-plan Provider/Practitioner is qualified to provide family-planning services based on the licensed scope of practices.
- The out-of-plan Provider/Practitioner must submit the claim to MHC on a HCFA 1500 form.
- The out-of-plan Provider/Practitioner must provide pertinent medical records sufficient to allow MHC to meet case management responsibilities.
- MHC will reimburse contracted Providers/Practitioners at contracted rates.

MHC will reimburse non-contract, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate. Reimbursement for family-planning services will only be made if the

Provider/Practitioner submits treatment records or documentation of the member's refusal to release medical records to MHC along with billing information.

Policies and Procedures

PCPs or their staff may obtain detailed information on any MHC policy/procedure by contacting the Provider Services Department at (888) 665-4621. Available policies include, but are not limited to:

- Confidential Access to Services to Minors
- Access to Health Care
- Collection, Use, Confidentiality, and Release of Primary Health Care Information
- Safeguarding and Protecting Medical Records

SEXUALLY TRANSMITTED DISEASES (STD)

MHC members may access care for STDs without prior authorization requirements as stated in its contracts with the California Department of Health Care Services. In accordance with Federal Law, Medi-Cal members are allowed freedom of choice of Providers/Practitioners when seeking STD services, without prior authorization. STD services include education, prevention, screening, counseling, diagnosis, and treatment.

Participating Provider/Practitioner Responsibilities

Participating Primary Care Practitioners (PCPs) are responsible for the primary medical care of STDs. The PCP may perform services or refer members to Local Health Department clinics, participating specialists, or upon request of the member, to out-of-plan Providers/Practitioners. Each PCP is responsible to report certain information regarding the identification of STDs to the Local Health Department within seven (7) days of identification.

When reporting to the Local Health Department, the following information must be included:

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

The PCP will provide and document preventive care and health education, counseling, and services at the time of any routine exam for all members with high-risk behaviors for STDs. Access to confidential STD services by minors is a benefit of MHC.

Minors

Members age 12 and over may access STD services without parental consent. MHC Policy, Confidential Access to Services for Minors, may be obtained by contacting the Provider/Practitioner Quality Improvement Department.

Non-Participating Provider/Practitioners

MHC requests that non-participating Providers/Practitioners contact the Customer Services Department at MHC to confirm eligibility and benefits and to obtain billing instructions for

MHC members. Non-participating Providers/Practitioners are requested to contact the affiliated health plan's Member Services Department to confirm eligibility and benefits and to obtain billing instructions. The non-participating Providers/Practitioners will also be given the name of the member's PCP to arrange for follow-up services. If the non-participating Provider/Practitioner contacts the PCP directly, the PCP is responsible for coordinating the member's care with the non-participating Provider/Practitioner.

If the non-participating Provider/Practitioner requests Care Management services, the call will be transferred to MHC's Care Management Department. The Case Manager will then arrange for any necessary follow-up care and will coordinate with the member's PCP as necessary.

Member Education

MHC provides member education on STDs which includes disease-specific material, right to out-of-plan treatment, cost, assessment for risk factors, and the methodology for accessing clinical preventive services. Members are advised of these services in the Evidence of Coverage which is mailed at the time of enrollment and annually thereafter. MHC Health Education Department will send STD health education information to Providers/Practitioners upon request. See the section in this manual entitled "Health Education" for instructions on ordering materials and order forms.

Provider/Practitioner Guidelines for STD Episodes

For the purposes of providing reimbursement to the Local Health Department for sexually transmitted diseases, an episode is defined based upon the specific sexually transmitted disease diagnosed as follows:

- Bacterial Vaginosis, Trichomonosis, Candidiasis Initiation of treatment of vaginal or urethral discharge for symptoms and signs consistent with any one or a combination of these diagnoses is considered an episode, and one (1) visit is reimbursable.
- Primary or Secondary Syphilis - Initial visit and up to five (5) additional visits for clinical and serological follow-up and re-treatment, if necessary, may be required for certain high-risk individuals. A maximum of six (6) visits per episode is reimbursable. Documentation should include serologic test results upon which treatment recommendations were made.

NOTE: Members who are found to have a reactive serology, but show no other evidence of disease, should be counseled about the importance of returning to the Provider/Practitioner for follow-up and treatment of possible latent syphilis. For female members of childbearing age who refuse to return to the Provider/Practitioner for their care, up to six (6) visits are reimbursable for treatment and follow-up.

- Chancroid - Initial visits and up to two (2) follow-up visits for confirmation of diagnosis and clinical improvement are reimbursable.
- Lymphogranuloma Venereum, Granuloma Inguinale - Based upon the time involved in confirming the diagnosis and the duration of necessary therapy, a maximum of three (3) visits is reimbursable.
- Herpes Simplex - Presumptive diagnosis and treatment (if offered) constitute an episode, and one visit is reimbursable.

- Gonorrhea, Non-Gonococcal, Urethritis and Chlamydia - Can often be presumptively diagnosed and treated at the first visit, often with single-dose therapy. For individuals not presumptively treated at the time of the first visit, but found to have gonorrhea or chlamydia, a second visit for treatment will be reimbursed.
- Human Papilloma Virus - One (1) visit reimbursable for diagnosis and initiation of therapy with referral to PCP for follow-up and further treatment.
- Pelvic Inflammatory Disease - Initial visit and two (2) follow-up visits for diagnosis, treatment, and urgent follow-up are reimbursable. Member should be referred to PCP for continued urgent follow-up after the initial three (3) visits have been provided by the LHD.

Reimbursement

Participating Providers/Practitioners must bill MHC or the appropriate capitated IPA/Medical Group in accordance with their Provider/Practitioner agreement and all applicable procedures. If you are an individually contracted Provider/Practitioner rendering referred or authorized STD services, you are reimbursed at the lowest allowable Medi-Cal fee-for-service rate determined by DHCS if a specific rate has not been included in your Provider/Practitioner contract.

If the STD service is denied, for example, those patients not eligible under the Medi-Cal program, the claim will be sent to the Provider/Practitioner of service to protect the confidentiality of the member.

If the member received STD services from a non-participating Provider/Practitioner and was required to pay out-of-pocket for the services, the member must bill MHC or the affiliated health plan or IPA/Medical Group, according to their affiliation. The billing address is located on the back of the member's ID card.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING AND COUNSELING

MHC is responsible for promoting access to confidential HIV testing and counseling services available to its members. MHC is to assist in the coordination of care and follow-up with the Local Health Department (LHD). MHC ensures coordination of Medical Case Management and AIDS Waiver Case Management in developing a comprehensive approach to achieve healthy outcomes for MHC members diagnosed with AIDS or symptomatic HIV disease. MHC is responsible for ensuring that its members have access to appropriate and confidential HIV testing and counseling services and that Providers/Practitioners are reimbursed properly for services rendered. MHC must also ensure that the collection, management, documentation, and release of information regarding HIV tests are handled in compliance with state and federal laws and regulations. In addition, MHC must ensure the safety and confidentiality of its members and staff. MHC's network of PCPs will perform or order confidential HIV testing, counseling, and follow-up services, when indicated. MHC members may also receive HIV testing and counseling from a LHD or from other non-participating family-planning Providers/Practitioners.

Local Health Department Coordination

MHC will collaborate with the Local Health Department for the following:

- To develop a Memorandum of Understanding (MOU) or a cooperative agreement addressing HIV testing and counseling services
- To coordinate the development of applicable policies and procedures
- To identify strategic opportunities to share resources, which maximize health outcomes
- To routinely communicate and facilitate optimal data and information exchange
- To ensure appropriate case management collaboration
- To work to resolve conflict at the local level

Provider Training and Education

The Provider Services Department at MHC, in collaboration with the LHD, provides ongoing program education and training on HIV/AIDS services. This training provides information regarding the eligibility criteria for the AIDS Waiver Program. The MHC Provider Services Department maintains a list of all agencies providing AIDS Waiver Program services within the geographic region. The MHC Provider Services Department, in collaboration with the LHD, educates providers on the conditions that make an individual eligible for AIDS Waiver Program Services and the referral process.

PCP Responsibilities

PCPs will routinely obtain a sexual history and perform a risk factor assessment for each of their members. When appropriate, the Provider/Practitioner will screen for HIV infection with pre and post-test counseling. The PCP's initial disclosure of HIV test results to the member can greatly affect the member's knowledge of, and attitude about his/her condition. Prior to disclosing results, the PCP will assess the degree to which the member, parent, or guardian is prepared to receive the results. The PCP will consider social, cultural, demographic, and psychological factors. Disclosure and counseling will always take place face-to-face. Immediate interventions may include assessing the member for potential violence to him/herself or others, informing the member of available services, making referrals as necessary, and addressing the prevention of HIV. PCPs will educate the member regarding the State's HIV reporting requirements.

Confidentiality

Counseling suggestions for the HIV positive members include:

- Providing information on available medical and mental health services as well as guidance for contacting sexual or needle-sharing partners. HIV-infected individuals should be counseled with regard to safe sex, including the use of latex condoms during sexual intercourse.
- Describing the symptoms of common diseases that occur along with HIV and AIDS and when medical attention should be sought.

Counseling suggestions for the HIV negative member may include:

- Not exchanging bodily fluids unless he/she are in a long-term mutually monogamous relationship with someone who has tested HIV antibody-negative and has not engaged in unsafe sex for at least six (6) months prior to or at any time since a negative test.
- Using only latex condoms along with a water-soluble lubricant.
- Reminding never to exchange needle or other drug paraphernalia.

Reporting of Test Results

The reporting of HIV test results is not mandatory at this time. However, MHC requires Providers/Practitioners to report to the Department of Health Care Services and the County Health Officer whenever a patient is diagnosed with AIDS.

When reporting AIDS cases, the report is to include the name, date of birth, address, and social security number of the patient, the name of the Provider/Practitioner and clinic, and date of the patient's hospitalization as appropriate. An AIDS Adult Confidential Case Report Form is completed for members age 12 and over.

Screening and Testing

MHC requires the written consent of the patient prior to testing of patient's blood for antibodies to the causative agents of AIDS (HIV test). The patient's written consent is obtained by the Provider/Practitioner/designee. If blood is drawn at the Provider/Practitioner's office, the consent will be filed in the member's medical records and the blood sample will be forwarded to the laboratory. Initial evaluation by the PCP will include a history and physical for all members suspected of HIV infection. The member's history is key to differential diagnosis, primary prevention, and partner notification.

The following information should be obtained and documented in the member's medical record:

- Member's sexual orientation
- Intravenous drug abuse history
- Transfusion history
- Incidents of sexual contact with a person(s) with AIDS or who subsequently developed AIDS
- History of homosexual or heterosexual promiscuity
- History of work related exposure

The physical exam of the HIV member will include all body systems and may prove to be entirely normal. Abnormal findings range from those completely non-specific to those highly specific for HIV infection. The member may also present with symptoms to a large number of diseases that are commonly seen in HIV infected members. A complete physical examination will be documented in the member's medical record and will include:

- All body systems
- Visual acuity
- Oral cavity
- Gynecological exam

Common complaints may include:

- Systemic, i.e. fever, night sweats, weight loss, fatigue
- Gastrointestinal, i.e. nausea, vomiting, diarrhea, abdominal pain
- Respiratory, i.e. shortness of breath, cough, sinus pain
- Central nervous system, i.e. visual changes, headache, focal neurological deficits, seizures
- Peripheral nervous system, i.e. numbness, tingling, pain to the lower extremities
- Musculoskeletal, i.e. joint swelling and pain, muscle tenderness, proximal weakness

Initial laboratory evaluations may include, but are not limited to, any of the following *when indicated*:

- ELISA (Enzyme-Linked Immunosorbent Assay)
- Western Blot (after 2 positive ELISA tests)
- CBC and blood chemistry when transaminase
- Hepatitis B and C serology
- CD4 count - absolute and percent
- Baseline serology for cytomegalovirus (CMV) toxoplasmosis, and crytoantigen
- Septum culture
- Blood culture (if temperature is greater than 38.5 C)
- Wright-Giemsa stain
- Bronchoalveolar lavage
- Rapid Plasma Reagin (RPR) or Venereal Disease Research Laboratory (VDRL), i.e. rules out Syphilis, screen for other sexually transmitted diseases as indicated.

Confidentiality of Test Results

Results of blood tests to detect antibodies to the probable causative agent of AIDS (HIV test) are confidential and disclosure is limited. Results may be disclosed to any of the following persons without written authorization from the subject: To the subject of the test or the subject's legal representative, conservator, or to anyone authorized to consent to the test for the subject

Disclosure of Information

- Test results are placed in the medical record clearly marked "Confidential" for the use of the treatment team at MHC.
- To a Provider/Practitioner of care who procures, processes, distributes, or uses human body parts donated pursuant to the Uniform Anatomical Gift Act.
- The Provider/Practitioner who ordered the antibody test may, but is not required to, disclose
 - positive test results to a person reasonably believed to be a sexual partner or a person with whom the patient has shared the use of hypodermic needles (provided the Provider/Practitioner does not disclose identifying information about the test subject to the individual) or to the County Health Officer. He/she will not be civilly or criminally liable for doing so.
- MHC providers/practitioners who disclose the results as outlined above are required to document such release, including first name and last initial of the person mentioned in the medical record of the patient, also giving the reason for the release, i.e. believed sexual partner, possible shared needles, etc.
- Prior to disclosing results to a third party, the Provider/Practitioner must first discuss the results with the patient, counsel the patient, and attempt to obtain the patient's voluntary, written consent and authorization to notify the patient's contacts.
- If the Provider/Practitioner discloses the information to a contact, the Provider/Practitioner must refer that person for appropriate care.

Release of HIV Test Results

In all cases, except as mentioned previously, written authorization for release of HIV test results is required.

- Such disclosure includes all releases, transmissions, dissemination, or communications whether they are made orally, in writing, or by electronic transmission.
- A valid authorization to release results of a blood test to detect antibodies of HIV is to be in writing and include to whom the disclosure must be made.
- Written authorization is required for each separate disclosure of test results.
- HIV test results will not be released pursuant to a subpoena for medical records unless accompanied by a court order directing the release.
- The current applicable Release Form will be used for all releases under this section.
- All requests for release of HIV test results will be verified for appropriateness.
- Providers/Practitioners and employees of MHC are not permitted to remove the HIV test from the medical record or photocopy the HIV test results under any circumstances except as heretofore described.

Penalties for Improper Disclosure of Test Results

Health and Safety Code, Section 199.21, provides penalties for the negligent or willful disclosure of results of a blood test to detect antibodies to the probable causative agent of AIDS to any third party. The penalty applies if the disclosure is not authorized by the patient or by law.

- If an improper disclosure resulted from negligence there may be a fine up to \$1,000 plus court costs.
- If an improper disclosure resulted from a willful act, there may be a fine up to \$5,000.
- If an improper disclosure, whether negligent or willful, results in economic, bodily, and/or psychological harm to the subject of a test, the person who made the improper disclosure may be found guilty of a misdemeanor and fined up to \$10,000 or be imprisoned in county jail for up to one (1) year, or both, and may also be liable to the subject of the test for all actual damage caused, including economic, bodily, and/or psychological harm.
- Any employee who releases information regarding HIV testing, whether results are positive or negative, in violation of this policy has also breached MHC's confidentiality policy and is subject to such disciplinary action as is warranted, up to and including dismissal from employment or service.

Continuing Care

As the disease progresses, and depending on any accompanying diseases the member acquires, referrals to subspecialties will be initiated as needed. The PCP will consider management by an infectious disease specialist or HIV specialist when CD 4+ 200 cells u/L or the member develops clinical AIDS. During the terminal phase of care, issues such as advanced directives, durable power of attorney, and hospital care will be addressed by the PCP. The Medical Case Manager will monitor and coordinate care and services provided to HIV/AIDS members by PCPs as well as any out-of-plan providers.

Out-of-plan Providers/Practitioners

Members may access out-of-plan Providers/Practitioners for diagnosis of HIV/AIDS. MHC will reimburse contracted Providers/Practitioners at contracted rates. MHC will reimburse non-

contracted, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate, unless otherwise negotiated. The diagnosis, counseling, and treatment of HIV/AIDS will be reimbursed if the Provider/Practitioner submits treatment records or documentation of the member's refusal to release records along with billing information. Medical records obtained from out-of-plan Providers/Practitioners other than the member's PCP will be shared with the PCP for the purposes of assuring continuity of care.

If a member refuses to release the medical records required for billing, the out-of-plan Provider/Practitioner must submit documentation of such refusal. Properly billed claims from out-of-plan Providers/Practitioners will be paid timely and in accordance with the Knox-Keene Act (amended).

TUBERCULOSIS (TB) SCREENING AND TREATMENT AND DIRECT OBSERVED THERAPY (DOT)

The estimated number of persons in the United States with latent tuberculosis (TB) infection is ten (10) to fifteen (15) million. Studies have shown the treatment of such patients with at least six (6) months of antibiotics can significantly reduce progression to active tuberculosis. Preventive treatment is ninety percent (90%) effective when the patient compliance is good. Tuberculosis is associated with considerable morbidity from pulmonary and extra pulmonary symptoms.

Direct Observed Therapy (DOT) Services are offered by Local Health Departments to monitor those patients with active tuberculosis who have been identified by their Provider/Practitioner as at-risk for non-compliance with treatment regimen. DOT is a measure both to ensure adherence to tuberculosis treatment for at-risk members who either cannot or likely will not follow the treatment regimen and to protect the public health.

MHC and Providers/Practitioners coordinate and collaborate with Local Health Departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. MHC's guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), and the Advisory Committee for Elimination of Tuberculosis (ACET). MHC coordinates with LHDs for the provision of Direct Observation Therapy (DOT), contact tracing, and other TB services. Members meeting the mandatory criteria for DOT are identified and referred to LHDs.

TB screening and treatment services for members are covered responsibilities under the Two-Plan Model Contract. MHC collaborates with LHDs to control the spread of TB and to facilitate access to TB treatment. MHC coordinates with LHDs to establish an effective coordination of care to achieve optimum clinical outcomes for members. Early diagnosis, immediate reporting to LHDs, and appropriate TB treatment are critical to interrupting continued transmission of TB. MHC informs PCPs that they must report known or suspected cases of TB to the LHDs TB Control Program Office within one (1) day of identification, per Title 17, CCR, Section 2500. PCPs will coordinate and collaborate with LHDs for TB screening, diagnosis, treatment, compliance, and follow-up of MHC members. MHC medical policy guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society ATS, CDC, and

the ACET. MHC will coordinate with LHDs for the provision of (DOT), contact tracing, and other TB services. MHC members meeting the mandatory criteria for DOT are identified and referred to LHDs. MHC will direct diagnosed Class III and Class V TB cases to the applicable LHD for treatment. The PCP is responsible for coordination of care with the LHD and for meeting any additional healthcare needs of the member, unrelated to TB services.

Tuberculosis Control Strategy

MHC's TB control strategy for members include the following: continued collaboration, communication, and contracting with the LHDs in the areas of public health coordination, community education/training, Provider/Practitioner and Provider/Practitioner staff education/training, referral process, screening/ treatment, DOT, and case management processes. The control strategy includes the following:

- Communicating with the LHDs in order to facilitate an effective TB prevention, screening, and treatment process
- Identifying and reporting of TB cases to LHD
- Providing educational programs to the members residing in various counties
- Providing education and resources to Provider/Practitioners and Provider/Practitioner's staffs regarding the prevention, screening, identification, and treatment of TB
- Providing MHC members diagnosed with TB with early and appropriate treatment
- Promoting compliance with treatment programs
- Preventing the spread of TB

Screening for Tuberculosis Infection

Screening for TB is done to identify infection in members at high-risk for TB who would benefit from therapy. Screening is also done to identify members with active TB disease who need treatment. An assessment of risk for developing TB must be performed as part of the initial health assessment required within ninety (90) days of enrollment with MHC. MHC collaborates with the LHD TB Control Programs to identify refugees who are possible candidates for local refugee health clinic services.

Tuberculosis Risk Assessment in Adults

For adult members, an assessment of risks for developing TB will be performed as part of the initial health assessment required to be conducted within ninety (90) days of enrollment. TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease. High-risk individuals include:

- Persons with medical risk factors associated with TB
- Immigrants from countries with high TB prevalence
- Alcoholics
- Drug users
- Residents of long-term care facilities

Tuberculosis Risk Assessment in Children

For MHC members under age 21, assessment for risk factors for developing TB and tuberculin skin testing must be conducted in compliance with current American Academy of Pediatric Requirements. The risk factors include the following:

- Those who have had contact with a person(s) with infectious TB

- Those who are from, or who have parents who are from, regions of the world with a high
 - prevalence of TB
- Those with abnormalities on chest roentgenogram suggestive of TB
- Those with clinical evidence of TB
- Children who are HIV-sero positive
- Those with immunosuppressive conditions
- Those with other medical risk factors such as Hodgkin's Disease, lymphoma, diabetes mellitus, chronic renal failure, and/or malnutrition
- Incarcerated adolescents
- Children who are frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, residents of nursing homes, and migrant farm workers

TB Skin Testing Protocols

Mantoux tuberculin skin testing is the standard method of identifying persons infected with TB. The Mantoux test will be given and read by qualified staff. Steps of tuberculin skin testing are as follows:

- TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease.
- The screening test to be used is the Mantoux tuberculin test. The multi-puncture test must not be used.
- Trained personnel must read the skin test results and record the result in millimeters.
- Tuberculin testing will be done by injecting five (5) Tuberculin Units (TU) of PPD (0.1 ml) intradermally.
- Previous BCG Vaccination is never a contraindication to tuberculin testing.
- Members with a history of previous positive PPD (Mantoux) should not be retested.
- Interpretation of the test result: The test will be read forty eight (48) to seventy two (72) hours after the injection. In the general member population, a reaction of greater than or equal to 10mm of induration will be considered a positive test.
- Members with a positive skin test will have a chest x-ray to exclude pulmonary TB.
- Members with an asymptomatic infection (positive skin test, but no evidence of disease on chest x-ray) will be treated with INH alone. In infants and children, recommended duration of INH is nine (9) months. Note: INH is given daily, 10 mg per kg, in a single dose, or 300 mg/day in adults.
- Children receiving INH do not need Pyridoxine supplements unless they have nutritional deficiencies. (Pyridoxine is recommended for children and adolescents on meat or milk deficient diets, or with other nutritional deficiencies, breast-feeding infants, and women during pregnancy.)
- Immunizations - Members who are receiving treatment for TB may be given measles vaccine or other live virus vaccines as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications.
- Adults treated with INH should have baseline liver function tests (LFT) done. LFTs should be repeated monthly. In children, the incidence of hepatitis during INH therapy is so low that routine determination of LFTs is not recommended.
- Adults under age 35 should be treated with INH for nine (9) months if they have a positive PPD and a negative chest x-ray. In members 35 years and over, the risk of

hepatic toxicity from INH outweighs the risk of progression of TB and is not recommended.

The definition of a positive tuberculin skin test is as follows:

- Greater than or equal to five (5) mm for persons known or suspected to have HIV infections
- Contact with an infectious case of TB
- Person with an abnormal chest radiograph, but no evidence of active TB
- Greater than or equal to ten (10) mm, all persons except those listed above
- Greater than or equal to fifteen (15) mm. In California, this cut off is not recognized by Public Health Departments.

Tuberculin skin tests are not recommended for persons at low-risk for TB infection. Tuberculin skin test conversion is defined as an increase of at least 10mm of induration from below 10mm to greater than or equal to 10mm within twenty four (24) months of a documented negative to a positive tuberculin skin test. If the test is positive, a chest x-ray must be done. Since a positive TB test does not necessarily indicate the presence of active TB disease, an individual showing a positive TB test requires further screening with other diagnostic procedures.

If the member does not return to have his/her skin test read, follow-up will be conducted by the PCP according to the missed appointment policy and process with documentation of steps taken in the member’s medical record.

Classification of TB

CLASS	TYPE	DESCRIPTION
0	TB exposure; Not infected	No history of exposure Negative reaction to tuberculin skin test
I	TB exposure; No evidence of infection	History of exposure Negative reaction to tuberculin skin test
II	TB infection; No disease	Positive reaction to tuberculin skin test Negative bacteriologic studies (if done) No clinical or radiological evidence of TB
III	Current TB disease	<i>M. Tuberculosis</i> cultured (if done) OR Positive reaction to tuberculin skin test AND Clinical or Radiological evidence of current disease
IV	Previous TB disease	History of episode(s) of TB OR Abnormal but stable radiograph findings Positive reaction to the tuberculin skin tests Negative bacteriologic studies (if done) AND No clinical or radiographic evidence of current disease
V	TB suspected	Diagnosis pending

Preventive Therapy

The following classes of members may be eligible for preventive therapy if they have not received a prior course of anti-TB treatment. Before starting preventive therapy, active TB must first be excluded. It is essential to obtain a chest x-ray when evaluating a person for TB.

Bacteriologic studies should be obtained for all members with an abnormal chest x-ray.

- TB Class II - TB infection, no disease: a member with a positive reaction to tuberculin skin test, no clinical and/or radiographic evidence of tuberculosis, and a negative bacteriologic study.

- TB Class IV - TB, no current disease: a member with a positive reaction to a tuberculin skin test, abnormal, but stable radiographic findings over a period of at least three (3) months, or the radiographic abnormalities of known duration, negative bacteriologic studies, and no other clinical or radiographic evidence of active tuberculosis.

Immunizations - Members who are receiving treatment for TB can be given measles vaccine or other live virus vaccinations as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications.

Persons with the following conditions that have been associated with an increased risk of TB should be started on preventive therapy, regardless of age:

- Drug abuse, especially with injecting drug use
- Diabetes mellitus, especially insulin dependence
- Prolonged corticosteroid therapy
- Other immunosuppressive therapy
- Cancer of the head and neck
- Hematological and Reticuloendothelial disease
- End-stage renal disease
- Intestinal bypass or gastrectomy
- Chronic malabsorption
- Low body weight
- Malnutrition and clinical situations associated with rapid weight loss

Clinical trials have shown that daily isoniazid (INH) for six (6) - twelve (12) months is highly effective in reducing the risk of TB. Every effort will be made by the PCP and the Local Health Department TB Control Program to ensure that members adhere to preventive therapy for at least six (6) months. Every effort will be made to ensure compliance for six (6) - twelve (12) months. For close contacts with infectious members who have INH-resistant TB, preventive therapies with Rifampin (RIF) should be considered. RIF should also be considered for INH-intolerant members.

For documented recent converters who were contacts to cases with monoresistance to INH, RIF should be given for six (6) months; longer duration recommended for immunocompromised individuals.

Standard Initial Regimes

All TB cases, TB Class III, or TB Class V individuals in California should be started on a four (4) drug regimen of INH, RIF, Pyrazinamid (PZA), and Ethambutol (EMB), unless contra- - indicated. The treatment may be given in three (3) ways:

- Daily treatment regime: Drugs should be given together; dosages should not be split.
- Bi-weekly regime: Four (4) drug therapies, administered daily for two (2) weeks and then two (2) times a week for six (6) weeks. This sequence should then be followed by therapy with INH and RIF given two (2) times a week for sixteen (16) weeks.
- Thrice weekly treatment regime: Three (3) times weekly from the beginning; all four (4) drugs must be given for six (6) months.

For number one (1) above, EMB should be continued until drug susceptibility results are available and resistance to INH and RIF has been excluded. PZA is continued for the first two (2) months. RIF and INH are continued for a total of six (6) months. Intermittent therapy (see above) should only be given to directly observed therapy members. If cultures remain positive beyond two (2) months of treatment, therapy should be prolonged. Ideally, treatment should be continued at least six (6) months after the culture converts to negative.

Case Management

Management of members with suspected or diagnosed TB will be referred to the Case Management program of MHC or its affiliated health plan. The Case Management staff will notify the Local Health Department TB Control Program of the designated MHC Provider/Practitioner or staff responsible for coordination of TB care with the LHD TB Control Program. MHC will promptly notify the LHD TB Control Program of any changes in the Provider/Practitioner assigned to a confirmed or suspected TB case within seven (7) days.

The PCP must respond to requests for information from the LHD TB Control Program in a timely manner and will consult with the LHD TB Control Program about treatment recommendations and protocols, as needed. The Case Management staff, PCP, and the LHD TB Control Program collaborate in identifying barriers to member compliance with self-administered treatment. Fixed-dose combination drug preparations will be available for members on self-administered therapy, and they are strongly encouraged for treatment of adults to promote compliance.

As agreed with the Local Health Department, the LHD TB Control Program will assign a TB Case Manager (TBCM) who will:

- Assess risk of transmission within two (2) working days of case notification
- Visit the member within seven (7) working days, depending on transmission risk factors
- Initiate contact investigations, when indicated
- Assess and address potential barriers to treatment adherence
- Verify initial information and collect additional information needed to complete the TB case report
- Visit the member as needed to assess and ensure treatment adherence
- Promptly notify MHC of assignment or change of the TBCM
- Respond to information requests from the PCP in a timely manner

Reporting

PCPs will comply with all applicable state laws and regulations pertaining to the reporting of confirmed and suspected TB cases to the LHD. The PCP will report known or suspected cases of TB to the LHD TB Control Program within one (1) day of identification. Reporting will be done in accordance with MHC Confidential Morbidity Reporting policy.

PCPs will promptly submit treatment plans, including dosage changes, to the LHD with updates at regular intervals as requested by the LHD until treatment is completed.* PCPs will notify the LHD when there are reasonable grounds to believe that a member has ceased treatment. Such grounds include member's failures to keep appointments, relocation without transferring care, or discontinuation of care. The LHD Local Health Officer may require MHC Providers/Practitioners at any time to report any clinical information deemed necessary including

the prompt reporting of drug susceptibility by the Local Health Officer to protect the member's health or the health of the public.

*NOTE: This is not applicable if the LHD is serving as the primary treatment center for the TB member.

Referrals

The PCP will identify Class III and Class V TB cases and will route a copy of the referral form to the LHD TB Officer. A copy of the referral form will also be sent to the MHC Utilization Management Department.

The PCP may make a referral to MHC or the subcontracted affiliated plan's Utilization Management Department for case management of services for members who are repeated no-shows for appointments. If the Case Manager determines that the member is considered lost to medical follow-up, the health plan's Case Manager will notify the LHD.

Members diagnosed with TB must be referred by the PCP to the LHD and the health plan's Utilization Management Department.

The following members may be appropriate for referral to the LHD and the health plan's Utilization Management Department:

- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence
- Persons with adverse reaction to TB medication
- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

Contact Investigation and Treatment

PCPs will cooperate with the LHD TB Control Program in conducting contact and outbreak investigations involving MHC members. The Case Management Department will be available to facilitate, and if necessary, direct the coordination efforts between LHD TB Control Program and the contracted Provider/Practitioners.

Contracted Provider/Practitioners must provide appropriate examination treatment to MHC members identified by the LHD as contacts in a timely manner, usually within seven (7) days. Examination reports will be reported back to the LHD in a timely manner. PCPs and/or the Case Management Department will promptly notify the LHD when contacts of MHC members are referred to the LHD TB Control Program for examination.

Educational Material

Educational material may be obtained for members from various resources including, but not limited to:

- MHC Health Education Department Telephone: (800) 526-8196, ext. 127532
- American Academy of Pediatrics, “Patient Medication Instructions: Isoniazid” Telephone: (800) 433-9016.
- American Lung Association, “Facts about Tuberculosis”. Telephone: (800) 586-4872.
- Krames Communications, “Understanding Tuberculosis”. Telephone: (800) 333-3032.
- American Thoracic Society, 61 Broadway, New York, 10006-2755. (212) 315-8600
- U.S. Centers for Disease Control and Prevention/National Centers for Prevention Services
- Division of Tuberculosis Elimination, 1600 Clifton Rd. NE Mail Stop E, Atlanta, Georgia 30333. Telephone: (404) 639-8135.

The MHC Education, Provider Services, and Care Management Departments will cooperate with the LHD TB Control Program to make health education resources available to MHC members, Provider/Practitioners, and Provider/Practitioner’s staff. This includes education to Providers/Practitioners and Provider/Practitioner’s staff on how to perform and interpret TB screening tests.

Direct Observation Therapy (DOT) for TB is not a covered service but is offered directly by the LHD. Any claims for DOT are to be submitted to the Medi-Cal field office, not to MHC.

DOT Referrals to LHDs

When a PCP identifies a TB patient who is at-risk for compliance with his or her treatment regime, the PCP will fax a copy of the DOT referral form obtained from the LHD to the Control Officer. The LHD must be notified when the PCP has reasonable grounds to believe that a patient has ceased treatment, failed to keep an appointment, has adverse drug reactions, relocated without transferring care, and/or has discontinued care.

The following members with diagnosed TB must be referred for DOT services:

- Members having multiple drug resistance (defined as resistance to INH and RIF)
- Members whose treatment has failed
- Members who have relapsed after completing a prior regime
- Children
- Adolescents
- Noncompliant individuals

Members with the following conditions should be considered for referral for DOT:

- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence
- Persons with adverse reaction to TB medication

- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

Follow-up Care

PCPs are required to coordinate with the LHD TB Control Officer and to provide follow-up care to all members receiving DOT services. PCPs should inform the LHD TB Control Program of any changes in the member's response to the treatment or drug therapy. PCPs will receive a periodic report from the LHD TB Control Program, which advises them of each member's treatment status. The LHD TB Control Program will send a copy of the member's medical record and final status report upon completion of the DOT services to the PCP.

The PCP will arrange for the member to receive a follow-up appointment in order to develop a follow-up treatment plan. The PCP will follow-up if the patient is a no-show for the scheduled appointment through telephone or letter, and will document such follow-up effort in the member's medical record. The PCP will notify the LHD TB Control Program if the member continues to miss follow-up appointments.

7.3 HEALTHCARE SERVICES: PEDIATRIC & CHILD HEALTH SERVICES

CHILDREN’S PREVENTIVE SERVICES INCLUDING CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) SERVICES

Children’s Preventive Services

The Children’s Preventive Services program is a preventive well-child screening program for children and adolescents who are 21 years of age and under. The Child Health and Disability Prevention (CHDP) provides complete health assessments for the early detection and prevention of disease and disability in children. The program ensures that eligible children receive periodic health assessments and have access to ongoing health care from a medical home.

Physician Certification (Suggested)

CHDP certification is provided at no cost by the county CHDP Program and usually involves an interview and office evaluation. Non-CHDP certified physicians may contact the State directly or the MHC Provider Services Department at (888) 665-4621 for assistance to help facilitate this process.

Appointments

Well child preventive care appointment with PCP should be scheduled within seven (7) working days of the request.

Components of Health Assessment

A CHDP provider conducts a complete health assessment on all of the following:

- Health history
- Developmental assessment
- Unclothed physical “head-to-toe” examination
- A Vision testing
- A Hearing testing
- A Dental assessment of mouth, teeth, and gums
- A Nutritional assessment
- Laboratory screening tests appropriate to age/sex, (e.g. anemia, diabetes and urinary tract infections)
- Tuberculin test
- Sick cell trait test, when appropriate
- Blood lead test per CHDP guidelines
- Immunization(s)
- Anticipatory guidance as delineated in the CHDP Health Assessment Guidelines
- Appropriate health education, including the harmful effects of using tobacco products and exposure to second hand smoke

Members 3 years of age or older are referred annually for routine dental care. A provider can directly refer the member to a dentist or call (800) 322-6384.

Referrals and Coordination of Care

One of the goals of the CHDP program is to find any medical, dental, nutritional and developmental problems that a child may have before the problems become too severe for treatment. Once a medical, dental, nutritional or developmental problem is identified during CHDP health exam, the child may need further diagnosis and/or treatment of that problem. If the child needs a specialty care, such as optometrist or a dentist, the CHDP provider is obligated to make the referrals to assist the family to obtain the care their children need. The PCP is responsible for the supervision of practitioner extenders, ongoing care, and the coordination of care for all services that the member/child receives. Medical Case Managers are available to provide care coordination if indicated and requested by the PCP.

If a member needs transportation assistance, but do not meet the criteria for non-emergent transportation, the PCP will refer the parent/guardian to the CHDP Program office for procurement of transportation.

Obtaining Consent

Physicians must obtain the voluntary written consent of the member (if over 18 years) or parent/guardian (if under 18 years) before performing a CHDP exam. Consent is also required for any release of information.

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

Certification for School Entry

California state law requires that a child entering first grade must provide their schools with a certificate documenting receipt of a health assessment or a waiver of the assessment signed by the parent or a legal guardian. A child's personal physician may certify the individual for school entry if there is documentation that the physician has performed a physical examination and provided ongoing care during the 18-month period prior to or within ninety (90) days following entrance into the first grade. The medical care must have included all applicable health assessment procedures. Providers should supply the parent or guardian of a child entering kindergarten or the first grade with a Report of Health Examination for School Entry Form (PM 171A) to show that the child has received the appropriate health assessments. Providers must supply certification for all children whether or not the CHDP program reimburses for the health assessment.

The CHDP program and local schools urge parents to schedule a health assessment for their child upon entry into kindergarten. If the parent or guardian refuses a health assessment, the parent or guardian must submit a waiver to the school.

Follow-Up for Missed Appointments

For members who are a "no-show" at the time of their appointment(s), the member (parent/guardian) should be followed-up with a telephone call and, if necessary, a letter from the physician's office to schedule another appointment. Documentation of the telephone call or a copy of the letter must be maintained in the member's medical record.

All physicians who deliver care to eligible CHDP members must complete a PM 160 INF (Information Only) Form. The PM 160 INF form is used for Medi-Cal members enrolled in a managed care plan and not used for billing purposes. The PM 160 INF form is used to monitor the quality of and compliance with CHDP screening requirements.

Where to Send Completed PM 160 Forms

- | | |
|-------------------------|--|
| Copy 1
(white/brown) | Send to: Molina Healthcare of California
Attn: CHDP Department
P.O. Box 16027
Mail Stop "HFW"
Long Beach, CA 90806 |
| Copy 2
(yellow) | Send to: Local County CHDP office
PLEASE ensure PCP (service site) address, number, and county code are completed in the lower left-hand corner of the form |
| Copy 3
(white) | Maintained in the member's medical record |
| Copy 4
(pink) | Given to the member (parent/guardian) at the time of the visit |

The PM 160 Information Only Form (PM 160 INF) must be completed for each child who receives a CHDP health assessment. All PM 160 INF forms must be complete and accurate. Incomplete forms will be returned to the physician of services for completion. MHC must submit the completed PM 160 INF forms to the Department of Health Care Services (DHCS) within thirty (30) days from the end of the month in which services were rendered.

Ordering PM 160 INF Forms

To order PM 160 INF forms, please contact Provider Services at (888) 665-4621 or visit MHC's website at <http://www.MolinaHealthcare.com>.

IMMUNIZATIONS

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for members under age 21. PCPs are responsible for the administration of immunizations to their patients. Immunization services may be accessed during any PCP visit. MHC does not require rescheduling of visits for immunizations for immediate evaluation unless the child has a medical contraindication to receiving immunizations at the time of his/her visit to the PCP. Local Health Departments (LHDs) may also administer immunizations to MHC Medi-Cal members. Go to www.cdc.gov to view the childhood immunization requirements. A sample Vaccine Administration Record for Children and Teens can also be found in Section 19, Exhibit 19M.

Additional information addressing protocols for care coordination and patient follow-up can be found in the Adult Preventive Care and Children's Preventive Services sections of this Manual.

MHC Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. They are updated annually. Age specific PHGs for members are available on the MHC webpage at: www.MolinaHealthcare.com. You may request a copy by contacting Provider Services at (888) 665-4621.

Participating Providers/Practitioners

PCPs are available to administer immunizations during routine office hours. The PCP also has the responsibility of updating the immunization card supplied by the Local County Health Department. Members are encouraged by MHC to set up evaluations for initial health assessments and immunizations during the first one hundred twenty days (120) of enrollment with MHC. MHC sends members welcome and reminder letters advising them of this service. Members will receive written notice from the PCP to prompt members to come in for needed immunizations.

At each visit the PCP will inquire if the member has received immunizations from another Provider/Practitioner. The PCP will also educate members regarding their responsibility to inform their PCP if they receive immunization elsewhere, i.e. non-plan Providers/Practitioners, LHD, etc. When a member experiences complications (e.g. infection or abscess), members should contact their PCP for follow-up care just as they would with any other medical condition or concern.

Upon request, the LHD will provide technical assistance, training, and material related to immunizations for MHC Providers/Practitioners. LHDs will assist MHC in their outreach efforts by conducting public education campaigns regarding immunizations. Provider/Practitioner bulletins will include updates of information on immunizations. Providers/Practitioners will be encouraged to participate in the Vaccines For Children (VFC) Program which is a federally funded program that provides free vaccines for eligible children and distributes immunization updates and related information to participating Providers/Practitioners. PCPs will maintain a current medical record on all members addressing applicable immunizations, notifications, and immunization services provided by an out-of-plan Provider/Practitioner. The PCP will cooperate with the out-of-plan Provider/Practitioner when requested to share member's immunization history. The PCP will document diligent effort in assessing the actual immunization status of the MHC member prior to any immunization services.

Local Health Department (LHDs)

In accordance with Department of Health Service (DHCS) guidelines, MHC will reimburse LHDs for certain immunizations and services without prior authorization. MHC requires that the LHD contact the member's PCP or Medi-Cal Member Services Department to confirm eligibility and benefits before administering the immunization. The LHD should verify the member's immunization status, as they will not be reimbursed for immunizations provided when the member's immunization status is current. The LHD must provide a copy of the member's immunization record with their itemized claim form. Upon request, MHC will help LHDs in obtaining the member's immunization history.

MHC will forward copies of a member's immunization records to the member's PCP for inclusion in his/her medical record. If the member receives an immunization from the LHD and complications arise, the member must get in touch with their PCP for care just as they would with any other medical condition.

Member Identification

All members are encouraged to maintain a current immunization status. Members requiring immunizations are identified through the following sources:

- Initial health assessments
- Primary care practitioners (PCPs) and specialists
- Quality Improvement Department
- Member Services Department
- Utilization Management Department
- Emergency room/urgent care facilities
- Local Health Departments
- Claims and encounter data
- Provider Service Department through Provider/Practitioner inquiries
- Members
- Health Education Department
- Schools

Member Outreach and Education

MHC's member outreach and health education efforts for both pediatric and adult immunization concentrate on informing members about the necessity of immunizations. The MHC Health Education Department distributes member education via a member newsletter, website and other educational materials that include information promoting immunizations. The PCP is responsible to ensure the member is up to date with immunizations.

Promoting Access to Care

MHC promotes appropriate access to care as well as immunizations by offering Provider/Practitioner educational materials and Provider Online Directory on www.MolinaHealthcare.com. Members also have access to twenty four (24) hour Nurse Advice service, which includes answering questions on immunizations, and other health concerns.

Reporting of Vaccine Preventable Diseases

MHC will assist LHDs in educating Providers/Practitioners, including laboratories, about their responsibilities to report vaccine-preventable (and other infectious) diseases according to California Health and Safety Code regulations.

The PCP and health plans will cooperate and assist LHDs in informing Providers/Practitioners of reported disease outbreaks and implementation of control procedures.

Please refer to MHC Policy and Procedure titled QM 41, Confidential Morbidity Reporting to Public Health, for details. This report can be obtained by contacting the Provider Services

Department of MHC. Information regarding Confidential Morbidity Reporting is located in the Tuberculosis section of this Manual.

Public Health Coordination

MHC has collaborated with Local Health Departments to:

- Negotiate the Memorandum of Understanding
- Develop and coordinate policies and procedures
- Provide in-service training to internal staff and contracted Providers/Practitioners

VACCINES FOR CHILDREN PROGRAM

Vaccine for Children (VFC)

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for Medi-Cal members under age 21. Medi-Cal Providers/Practitioners are encouraged to participate in the Vaccine for Children (VFC) Program. This federally and State funded program furnishes free vaccines in bulk to enrolled Providers/Practitioners. All Medi-Cal eligible children may receive these vaccines.

Becoming a VFC Provider

Download and review the program's Provider Enrollment Packet from www.eziz.org. Complete enrollment forms and submit them to VFC. You may also FAX your request to VFC's Customer Service Center at (877) 329-9832 to request paper-based Provider Enrollment Packets. Be sure to include the name and mailing address of the person to whom the packet should be sent. For more details see our enrollment section at www.eziz.org.

Once your application is received, VFC reviews the paperwork for completion, conducts license verifications, and assigns the enrollment request to a VFC Representative in your region to conduct a New Provider Enrollment Site Visit. Once a New Provider Enrollment Site Visit is completed, and VFC has verified your practice is ready to receive and store VFC-supplied vaccines (vaccine storage units meet program requirements), VFC will assign your practice a unique Provider Identification Number (PIN), complete your enrollment, and issue a welcome letter to confirm enrollment. For more information on California VC Program, visit the website at www.eziz.org or contact VFC at: Phone: (877) 243-8832; Fax: (877) 329-9832.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SUPPLEMENTAL SERVICES

EPSDT Supplemental Services

EPSDT Supplemental Services are defined as medically necessary services, including EPSDT Case Management Services, which are not available to the Medi-Cal population over age 21 (e.g. not CHDP). EPSDT Case Management Services are those services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services.

Children and young adults under age 21 will be examined (screened) by health care Providers/Practitioners to determine their health needs for EPSDT Supplemental Services. Federal law requires that states provide medically necessary screening, vision, hearing, and dental services to Medi-Cal members under age 21. Any service that is medically necessary to

correct or ameliorate a defect, physical and/or mental illness or a condition must be provided, even if the service is not otherwise included in the Medi-Cal plan.

Member Coordination

For members, MHC will work with its delegated medical groups and IPAs to coordinate with PCPs to identify those who would benefit from these services. MHC will determine the medical necessity of EPSDT Supplemental Services according to the criteria established in Title 22.

Referrals

In most cases, PCPs will identify members in need of EPSDT Supplemental Services as part of regular health screening visits. It is also possible that the need for services will be identified by the member, the member's parents or other family member, the local CHDP program, or another health professional. All referrals for EPSDT Supplemental Services will be directed to MHC's Utilization Management Department. MHC's Medical Director will review the request and determine the medical necessity of EPSDT Supplemental Services using the criteria established in Title 22.

Requests for prior authorization for EPSDT Supplemental Services will be accompanied by the following information:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset and etiology if known
- Clinical significance or functional impairment caused by the illness or condition
- Specific types of services to be rendered by each discipline with Provider/Practitioner's prescription where applicable
- The therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
- Record of previously provided health care services and results demonstrated by prior care
- Any other documentation available that may assist the department in making its determination. EPSDT Supplemental Services must meet standards as determined by the Department of Health Care Services (DHCS)

Procedure

MHC-eligible Medi-Cal members will be identified for EPSDT Supplemental Services by the PCP. EPSDT Supplemental Services will be determined to be medically necessary if one (1) of the three (3) following conditions is met:

- The requested EPSDT Supplemental Service can meet existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population; or
- The requested EPSDT Supplemental Service can meet distinct EPSDT service specific requirements (please see "Service Specific Criteria" below); or
- If, regarding the criteria above, the first bullet below cannot be met and the second bullet below is not applicable to the service, then the requested EPSDT Supplemental Service must be evaluated under the expanded medical necessity criteria established in the EPSDT regulations in Title 22, CCR, Section 51340(e)(3), as summarized below:
 - The services are to correct or ameliorate defects or physical and mental illnesses or conditions discovered by the screening services.
 - The supplies, items, or equipment to be provided are medical in nature.

- The services are not requested solely for the convenience of the member, family, Provider/Practitioner, or other Provider/Practitioner of services.
- The services are safe and not experimental and are recognized as an accepted modality of medical practice.
- Where alternative medically accepted modes of treatment are available, the EPSDT Supplemental Services are the most cost effective. MHC may determine the most cost-effective setting for services on a case by case basis. Where the determination of cost-effectiveness involves an assessment of services not covered by MHC (i.e. home and community based waiver services or long-term care in a nursing facility), MHC will coordinate the determination of cost-effectiveness with DHCS.
- The services to be provided are generally recognized as an accepted modality of medical practice or treatment, are within the authorized scope of practice of the Provider/Practitioner, and are an appropriate mode of treatment for the medical condition of the beneficiary.
- There is scientific evidence, consisting of well-designed and conducted investigations published in peer reviewed journals, demonstrating that the service can produce measurable physiological alterations beneficial to health outcomes, or in the case of psychological or psychiatric services, measurable psychological outcomes concerning the short and long-term effects of the proposed services. Opinions and evaluations published by national medical organizations, consensus panels, and other technology evaluation bodies supporting provision of the benefit will also be considered when available.
- The predicted beneficial outcome of the service outweighs potential harmful effects.
- The services improve the overall health outcomes as much as, or more than, established alternatives.

Examples of EPSDT Supplemental Services are cochlear implants, EPSDT case management services, and EPSDT Supplemental nursing services.

Prior authorization criteria developed by MHC will be the same or not be more restrictive than the criteria for approval set forth in the Medi-Cal fee-for-service (FFS) program.

Service Specific Criteria

There are two (2) kinds of services, orthodontic and hearing, which have service specific requirements. For orthodontic dental services to be provided as EPSDT Supplemental Services:

- The services must be medically necessary for the treatment of handicapping malocclusion pursuant to the criteria set forth in the Medi-Cal “Manual of Criteria of Medi-Cal Authorization.”
- The services must be medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions which meet the medical necessity criteria for either EPSDT diagnostic and treatment services or EPSDT supplemental services [Title 22, CCR, Sections 51340(e)(1) and (3)].
- Hearing aids and other hearing services are subject to the criteria for medical necessity applicable to services that are available to the general Medi-Cal population or the medical

necessity criteria for other EPSDT Supplemental Services. One (1) package of six (6) hearing aid batteries in size 675, 13, 312, or 10. A may be furnished on a quarterly basis without prior authorization. Batteries in different sizes or more frequent intervals may be requested through prior authorization.

- EPSDT Supplemental Services require prior authorization. Requests for prior authorization will be submitted to the Utilization Management (UM) Department at MHC and will be evaluated under the direction of the Medical Director.

When the standards set forth are not applicable to the services being requested, all of the following criteria, where applicable, will be reviewed:

- The services are necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions discovered by the screening services as defined in this policy.
- The supplies, items, or equipment to be provided are medical in nature.
- The services are not requested solely for the convenience of the member, family, PCP, or another Provider/Practitioner of services.
- The services are safe for the individual EPSDT-eligible beneficiary and are not experimental.
- The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the member's appearance. The correction of severe or disabling disfigurement will not be considered to be primarily cosmetic nor primarily for the purpose of improving the member's appearance.
- Where alternative medically accepted modes of treatment are available, the requested services are the most cost-effective

The services to be provided:

- Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed. Such acceptance will be demonstrated by scientific evidence, consisting of well-designed and well-conducted investigations published in peer review journals, and, when available, by opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence will demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.
- Are within the authorized scope of practice of the Provider/Practitioner and is an appropriate mode of treatment of the health condition of the member.

California Children's Services (CCS) Program for EPSTD Supplemental Services

When a member qualifies for services through CCS, MHC will defer to CCS for EPSDT Supplemental Services to the extent the services are provided by the CCS Program. MHC's Case Manager will ensure the appropriate utilization of local government agencies and organizations, including Regional Centers (RC), which provides EPSDT Supplemental Services. The Case Manager will follow-up with the member's PCP to ensure that referrals are made to the proper agencies and programs. If EPSDT Supplemental Services are not available to a local government agency or organization, the Case Manager will issue letters of authorization and work with MHC's provider contracting staff to provided negotiated claims payment instructions to EPSDT

Supplemental Services Provider/Practitioners, while continuing to provide care management services and updating the Member's individual care plan as necessary.

MHC's Case Managers will ensure that members under age 21 years, who qualify for EPSDT Supplemental Services, will be referred to an EPSDT Supplemental Provider/Practitioner or to an entity, such as RCs, that provide EPSDT Supplemental Services. If EPSDT Utilization Management Services are rendered by these referred Providers/Practitioners, the Case Manager of MHC, along with the appropriate Medical Director, will determine the medical necessity of diagnostic and medical treatment services. If EPSDT Utilization Management Services are not available from these referral Providers/Practitioners, the appropriate health plan will arrange and pay for all appropriate EPSDT Supplemental Services.

EPSDT Supplemental Services Providers/Practitioner

Any contracting MHC Provider/Practitioner, including a clinic, home health agency, medical equipment supplier, psychologist, speech therapist, or audiologist may provide EPSDT Supplemental Services subject to prior authorization through MHC's Prior Authorization process. PCPs are to refer to a MHC contracted Provider/Practitioner when possible.

- Provider/Practitioner will be credentialed by MHC according to the credentialing and re-credentialing process.
- Provider/Practitioner will be licensed or certified under state laws governing the healing arts to provide services.
- If licensure/certification is not available under state laws, the Provider/Practitioner will be otherwise authorized under state laws governing the healing arts to provide the service.
- Out-of-plan Providers/Practitioners will receive temporary privileges upon verification of licensure or certification, DEA status, and malpractice insurance as applicable.

Documentation

The member's medical record will reflect the following regarding EPSDT Case Management Services:

- Patient and family education regarding EPSDT Supplemental Services
- Referral to EPSDT Case Management Services as appropriate
- Reason for referral
- Patient/family reply to referral
- Subsequent care plan

Problem Resolution

Issues regarding responsibility for necessary EPSDT Supplemental Services will be resolved by MHC. The appropriate Medical Case Manager will continue to coordinate and authorize all immediate health care needs of the member in collaboration with the PCP until resolution is obtained.

CALIFORNIA CHILDREN’S SERVICES (CCS) PROGRAM

The California Children Services (CCS) Program provides medically necessary care and case management to children who meet CCS eligible conditions and who meet program eligibility requirements. The care is delivered by Providers/Practitioners in local communities and tertiary medical centers who meet CCS standards. The program performs other functions that include assessing the qualifications of and selecting appropriate Providers/Practitioners and sites for care, case management, determining appropriateness of care plans, and authorizing funding for services. The program is administered at the County level through a local CCS office. The four (4) components of the program are as follows:

- Diagnosis and treatment
- Medical therapy
- High-risk infant follow-up
- Human Immunodeficiency Virus (HIV) children’s screening program

The program’s working hypothesis is that children with complex, disabling conditions receive improved care and achieve better long-term outcomes when services are provided and coordinated through special care centers. These special care centers work with multi-disciplinary and multi-specialty teams that plan and carry out comprehensive, coordinated care for groups of illnesses, generally based on a particular organ system.

Benefits

CCS services are not covered under MHC; however, Primary Care Practitioners (PCPs) along with MHC’s Services Department will identify children with CCS eligible conditions and arrange for their referral to the local CCS office. The PCP will continue to collaborate in case management until the child’s CCS eligibility is established. The PCP will then continue to provide primary care services unrelated to the CCS condition. The MHC CCS Coordinator, in conjunction with the MHC Utilization Management Department will ensure coordination between its PCPs, CCS Specialty Providers, and the local CCS Program. Once the case is identified as a CCS eligible condition, the MHC CCS Case Manager will ensure that appropriate timely referrals are made to the applicable local CCS liaison within twenty four (24) hours. Any Provider/Practitioner, family member, or other interested party may make a referral to CCS.

Primary Care Practitioner Responsibilities

MHC is responsible for performing all preliminary testing and examination to determine a member’s diagnosis or condition and for sufficiently documenting the information to support the diagnosis in the member’s medical record. In accordance with CCS eligibility criteria, potentially eligible members are referred by the PCP or specialist physician to the CCS program for comprehensive case management.

MHC members enrolled in the CCS Program remain members of MHC. PCPs continue to be responsible for:

- Maintaining a comprehensive medical record on the CCS eligible member.
- Referring potentially eligible members to the appropriate CCS panel Provider/Practitioner or MHC CCS/Medical Case Manager.
- Providing overall primary case management for the member.

- Providing primary care and preventive care needs for non-related CCS conditions.

Case Managers coordinate with the PCP to provide all non-CCS related health care services. The secondary and tertiary care that is related to the member's CCS eligible condition is arranged and paid for by the CCS Program. Any care provided to a child enrolled in the CCS Program and related to the CCS condition must be prior authorized by the CCS Program, not MHC.

Eligibility Criteria

A medical eligibility criterion for CCS is based on a combination of ICD9-CM categories and the presence of certain qualifying conditions. The following listing by ICD9-CM categories is a guide for participating Providers/Practitioners to identify potential CCS eligible conditions.

Who Qualifies for CCS?

The program is open to anyone who:

- Is under 21 years old;
- Has or is suspected of having a medical condition that is covered by CCS;
- Is a resident of California; and
- Has a family income of less than \$40,000 as reported on the adjusted gross income on the state tax form or whose out of pocket medical expenses for a child who qualifies are expected to be more than 20 percent of family income; or the child has Healthy Families coverage.

There are no financial eligibility requirements for children who:

- Need diagnostic services to confirm a CCS eligible condition; or
- Are applying only for services through the Medical Therapy Program; or
- Have Medi-Cal full scope, no share of cost; or
- Have Healthy Families coverage; or
- Live on an Indian reservation.

What Medical Conditions Does CCS Cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. Listed below are categories of medical conditions that may be covered and some examples of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Diseases of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Diseases of the genitourinary system (serious chronic kidney problems)
- Diseases of the gastrointestinal system (chronic inflammatory disease, liver diseases)
- Serious birth defects (cleft lip/palate, spina bifida)
- Diseases of the sense organs (hearing loss, glaucoma, cataracts)
- Diseases of the nervous system (cerebral palsy, uncontrolled seizures)
- Diseases of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)

- Disabling conditions of poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care
- Diseases of the skin and subcutaneous tissue (severe hemangioma)

Special Programs

Several CCS programs are mandated for special segments of the county population and are described below. These are funded separately from the general CCS Program and have different policies and procedures to determine eligibility. The special therapy program usually operates within the public school context to provide long-term physical and occupational therapy.

Referrals to CCS

Referrals to CCS may be made by the PCP, other medical Providers/Practitioners, family members, or other community resources. Providers/Practitioners may refer the child directly to the CCS Program or to MHC CCS Coordinator for referral to CCS. The MHC CCS Coordinator will facilitate the CCS referral and assist the CCS liaison in gathering information as needed.

For those members that are directly referred to CCS, the CCS liaison is requested to notify MHC's CCS staff within twenty four (24) hours in order to facilitate information gathering for the eligibility process.

If the member is currently an inpatient and not in the CCS Program, the health plan UM Nurse Reviewer will assess the case for eligibility. When a case meets criteria, the UM Nurse Reviewer will refer the case to the health plan CCS staff for referral to the CCS Program. Referral for potential CCS eligible member may also be sent directly to CCS through a non-MHC facility staff member, such as the Social Worker, Case Manager, or Discharge Planner. When a CCS eligible member is received through a non-MHC source, the CCS liaison will inform the health plan CCS Staff of the referral within twenty four (24) hours of the accepted referral.

The PCP may identify a CCS eligible condition during the initial health assessment. In this case, the PCP may directly refer the eligible member to the CCS Program, or may refer the case to MHC or affiliated health plans CCS Staff for referral to CCS.

A community agency with no contractual relationship with MHC or its affiliated health plan may also identify a CCS eligible case and directly refer to CCS. In this case, the CCS liaison is required to notify MHC CCS Staff within twenty four (24) hours of the referral.

MHC or affiliated health plan's CCS Staff will continue to review inpatient and outpatient cases for appropriateness of care and service; however, the CCS liaison will generate approvals from services directly related to CCS benefits. The MHC CCS Staff will ensure communication between entities, including the PCP, MHC and CCS. Case Management services are not delegated to contracted groups or IPAs at this time.

Acceptance of any case for treatment is dependent upon factors relating to individual members, including:

- Prognosis
- Reasonable expectation of cure or restoration of useful function

- Availability of accepted forms of treatment
- Priority of need for medical care

Prior authorization for CCS services will be:

- Obtained directly by the PCP through the CCS Liaison, or
- Obtained by the MHC CCS/Medical Case Manager at the request of the PCP

CCS Application Form

Referrals to CCS must include medical documentation from the PCP or specialist. The referring Provider/Practitioner should also provide a CCS Application Form to the parent or guardian of a potentially eligible child and assist in the completion of the forms, if required. MHC Case Managers are also available to assist, as requested. It is strongly recommended that the CCS Application Form be completed to facilitate timely transition of care. Completion of the form is not required to receive services from CCS, but if the form is not filled out, the member may only receive Medi-Cal approved benefits and may lose his or her CCS eligibility if he or she loses Medi-Cal eligibility.

If the form is on file with CCS, CCS may provide services in addition to the Medi-Cal benefits and the member may continue to receive services through CCS even if he/she loses Medi-Cal eligibility. If the family does not agree to a CCS referral, the Case Manager, in conjunction with the Medical Director, will work with the PCP to develop a comprehensive case management plan to identify other available programs and services and to coordinate referrals. Documentation of the denial will be submitted to the CCS program.

CCS Application Processing

CCS eligible members will have case management services until their eligibility is established with the CCS Program. If the member is not accepted into the CCS Program, the case is referred back to the Plan's Medical Director for review. If the denial was appropriate, the referring Provider/Practitioner is notified, and the availability of other programs and services is explored. If the denial is deemed inappropriate, the Medical Director attempts to resolve the conflict at the local level. If this is not possible, conflict resolution will take place involving the State CCS Regional Office.

Acceptance into CCS Program

If the member is accepted into the CCS Program, the referring Provider/Practitioner and the member's family receives a Notice of Action from the CCS Program. The Case Manager calls the CCS Program to confirm the member's acceptance into the program and make contact with the CCS Case Manager. The MHC Case Manager will continue to receive regular status reports from the CCS Case Manager throughout the member's participation in the program. The member's PCP is also required to submit any additional requested medical records to assist in the development of the comprehensive case management plan.

OVERVIEW OF REFERRAL PROCESS

The CCS program is mandated to accept referrals for eligibility determination from any source. The following information must be provided on the standard referral form.

Date of Referral	Homes and Work Phone Numbers
Name of Patient	Diagnosis
Social Security Number (SSN)/Patient	Referring Practitioner/Agency
Date of Birth	Managed Care Plan (MCP)
Parent/Guardian Names	Medi-Cal Number
SSN of Parent/Guardian	Private Insurance Company or HMO
Home Address	Benefits or Services Requested

All relevant medical records must be submitted along with the referral. When this is not possible, the reports should be sent as soon as they are available.

Application

The family will be notified by CCS that a referral has been received and an application will be mailed to them for completion. This is not required unless the member will be participating in the Medical Therapy Unit Program. Financial eligibility is waived for Medi-Cal beneficiaries. Families who request assistance in completing their paperwork may schedule an appointment with the CCS office staff.

Program Eligibility

There are four (4) areas of eligibility that must be met in order to qualify for the CCS Program.

- **AGE:** The patient must be under 21 years of age
- **MEDICAL:** The patient must have a CCS eligible condition as documented in the medical reports
- **FINANCIAL:** Waived for Medi-Cal beneficiaries
- **RESIDENTIAL:** The patient resides in the applicable county (information for Medi-Cal beneficiaries will be based on the MEDS database)

The Medical Therapy Unit (MTU) is a component of the CCS Program that provides medically necessary physical and occupational therapy. The CCS therapy program works cooperatively with the State Department of Education. The family must complete the program application for this service.

The High-Risk Infant Follow-Up (HRIF) program is for “graduates” from a CCS approved neonatal intensive care unit that is at-risk of developing CCS eligible conditions.

If the medical documentation is insufficient, a letter will be sent to the Provider/Practitioner within five (5) days indicating the referral is in pending status. The fifteen (15) day time-frame begins again when the Provider/Practitioner responds to the CCS Status Report. If the patient is not medically eligible, a Notice of Action is sent to the Provider/Practitioner, the MCP, and the family when they have completed an application.

Enrollment/Program Agreement

If the patient is determined to be CCS eligible, a Program Services Agreement must be signed by the patient, parent, or legal guardian to indicate his/her enrollment in the CCS Program and agreement to abide by CCS policies and procedures. At this point, Medi-Cal beneficiaries are offered the full range of CCS benefits including those unique CCS benefits that are beyond the scope of the Medi-Cal program. This applies to Medical Therapy Unit (MTU) services only.

Authorizations

After CCS eligibility is confirmed, the patient may be directed to an appropriate CCS approved Special Care Center and/or CCS paneled Provider/Practitioner(s). Authorizations are sent by the CCS Program to Providers/Practitioners, with a copy to the MCP. This assures the Provider/Practitioner will be reimbursed on a fee-for-service basis for those specific services prior authorized by CCS. Reimbursement will be by either the Medi-Cal program for Medi-Cal benefits or by the CCS Program for unique CCS benefits. All authorizations are time-limited and are for care related to the CCS eligible condition only.

Emergency Referrals

Phone or FAX referrals for emergency hospital admissions must be sent to MHC within twenty four (24) hours or if on a weekend or holiday by the next working day. A “face sheet” or admission/registration form is acceptable as long as the admitting diagnosis and all secondary diagnoses are included.

Guidelines for Making Referrals

The Managed Care Plan (MCP) is responsible for the provision of primary care services, including most diagnostic procedures. The CCS Program will require, at the time of referral, that sufficient medical documentation be submitted to provide the evidence or to support the opinion that a CCS eligible condition exists. For example, the following documentation should be submitted for patients considered having eligible conditions:

- Asthma: Chest X-ray report showing changes characteristic of chronic lung disease. Abnormal pulmonary function tests during symptom free interval and post bronchodilator treatment.
- Cerebral Palsy: Detailed medical reports documenting the findings from a complete physical and neurological exam.
- Congenital Heart Disease: If a heart murmur is detected on routine physical exam, the patient should be seen by a pediatrician to confirm the significance of the murmur. CCS will not cover the cost of the pediatrician’s evaluation, but costs related to pediatric cardiology services after a functional murmur has been ruled-out are covered.
- Growth Hormone Deficiency: Growth charts documenting height of at least three (3) standard deviations below the mean for age or linear growth rate less than the 3rd percentile for age.
- Hearing Loss: Failure to pass at twenty five (25) decibels on two (2) separate screening audiometric evaluations performed two (2) to six (6) weeks apart. Alternatively, one (1), evaluation by a CCS paneled E.N.T. Provider/Practitioner or audiologist will suffice.
- HIV Infection: Infections that are symptomatic and/or being treated are eligible.

- Lead Poisoning: Single blood level of 20 ug/dl or greater if symptomatic. Otherwise, two (2) blood levels of 20 ug/dl or one, of 45 ug/dl or greater even if asymptomatic.
- Malocclusion: Patients without cleft palate or craniofacial anomalies who need orthodontic treatment should not be referred to CCS. Instead they should be referred to a Denti-Cal Provider/Practitioner for services.
- Scoliosis: X-ray reports showing curvature of the spine greater than twenty (20) degrees.
- Strabismus: Determination by an ophthalmologist that surgery is required to correct the condition.

Outpatient Referrals

Outpatients should be referred to CCS with medical reports and/or lab results when the presence of a CCS eligible condition is documented. When the diagnosis is unclear, the MCP should authorize an initial evaluation by the appropriate specialist within its Provider/Practitioner network, indicating “rule out CCS condition” on the authorization. Ideally, the specialist should also be CCS paneled allowing for continuity of care if an eligible condition is identified. However, the diagnostic report does not have to be from a CCS Provider/Practitioner.

The Provider/Practitioner is responsible for referring patients to CCS when a diagnosis is clearly eligible per the previous example. A formal denial from the MCP is not needed before a Provider/Practitioner can refer the patient to CCS. If the primary care practitioner initiates the referral, a desired specialist may be indicated.

The Provider/Practitioner should indicate the specific CCS services being requested on the Request for Prior Authorization of Services form. In particular, he/she should note if the referral is only for the Medical Therapy Unit (MTU) or High-Risk Infant Follow-Up (HRIF).

MTU Referrals

Patients being referred for MTU services only (occupational or physical therapy) do not need to meet financial eligibility, but those with HMO coverage must obtain prescriptions from their private Providers/Practitioners. A copy of the prescription and relevant medical records relating to therapy should accompany the referral. It is recommended that these prescriptions and medical assessments be done by a CCS paneled orthopedist, psychiatrist, or neurologist.

Inpatient Referrals

Hospitals are responsible for making referrals on patients with CCS eligible conditions admitted to their institutions. In order to reduce inappropriate referrals, inquiries about CCS eligibility by Providers/Practitioners should be made as soon as possible after admission.

Hospitals should send or fax a copy of the admission History and Physical with referral and Discharge Summary as soon as available even if the admission was prior authorized.

Authorizations for unexpected admissions will ordinarily be effective beginning the date that CCS receives notification. When the admission occurs on a weekend or holiday, CCS must be notified by the next working day. The same timeliness rules apply to requests for extending a previously authorized length of stay. Justification of continued hospitalization must accompany extension requests. A list of CCS Approved Hospitals can be found on the DHCS website at:

<http://www.dhcs.ca.gov/pcfh/cms/ccs/pdf/paneled/ahc.pdf>

EARLY START PROGRAM

The California Early Intervention Services Act, known as Early Start, is designed for children with developmental delays and disabilities or those at high-risk for developmental disabilities who are under 3 years of age. The program mandates services for children under age 3, who:

- Have an established condition that will likely lead to developmental delay.
- Have symptoms of significant developmental delay.
- Have a health history with a combination of bio-medical risk factors that places them at risk for developmental disability.

The goal of the Early Start Program is to promote and facilitate early identification and access to service delivery for eligible infants and their families. Regional Centers (RCs) and Local Education Agencies (LEAs) are designated as the local agencies to receive referrals, evaluate eligibility, conduct assessments for special needs, prepare an Individualized Family Service Plan (IFSP), and manage coordination of delivery.

Identification of Condition

The PCP should identify infants and toddlers from birth to 36 months with a disability that continues, or can be expected to continue indefinitely, and that constitutes a substantial handicap. These conditions may include, but not be limited to:

- Mental Retardation
- Cerebral Palsy
- Epilepsy
- Autism

In addition, handicapping conditions found to be closely related to mental retardation may require treatment similar to that required for mentally retarded individuals but will not include other handicapping conditions that are solely physical in nature.

The RCs are responsible for all children with broad developmental delays and disabilities, while LEAs have complete responsibility for all children with solely visual, hearing, or severe orthopedic impairments or combinations thereof. LEA eligible beneficiaries are those people who are eligible for services under Title XIX of the Social Security Act and certified for Medi-Cal who is one of the following:

- Under age 22 and enrolled in a school within an LEA in California. Any person who becomes 22 years of age while participating in an Individualized Education Plan or Individualized Family Service Plan may continue his or her participation in the program for the remainder of that current school year; or
- A Medi-Cal eligible family member of a student meeting the requirements noted above. Early Start Intervention Services, birth to 36 months, include all infants eligible under the California Early Intervention Services Act and include:
- Developmentally delayed in one (1) or more areas:
 - Communication
 - Physical and motor developmental, including vision and hearing
 - Cognitive development
 - Social and/or emotional development

- Adaptive development
- Established risk conditions expected to result in developmental delay, including:
 - Chromosomal disorders
- Inborn errors of metabolism
- Neurological disorders
- Visual and hearing impairments
- At high-risk for developmental disability

This program offers services to children under age 3 who:

- Have an established condition leading to developmental disability
- Are suspected of having significant developmental delay
- Have health history with a combination of bio-medical risk factors that places them at risk for developmental disability

Referrals to Early Start Program

- The PCP is responsible for identifying infants and toddlers who are at risk or suspected of having a developmental disability or delay by providing appropriate screening and assessment measures.
- The PCP will provide and/or arrange for all medically necessary services including diagnosis, specialty or subspecialty consultation, and therapy services necessary to correct and/or ameliorate the identified conditions.
- The PCP will refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation within two (2) working days of determining the need for developmental services.
- Referrals will be directed to the intake screener of the RC. (NOTE: When referring to both CCS and RC, one (1) referral will not delay the other.) The Provider/Practitioner will route member information to the RC as soon as possible, as the RC may take up to forty five (45) days to respond. Information should include the following:
 - Reason for referral
 - Detailed medical information and a developmental health evaluation, documenting health status including vision and hearing
 - Medical history
 - Results of developmental or psychological screening/assessment if available
- Specialty referrals are conducted through the referral and authorization process of MHC.
- Referrals to psychologists or psychiatrists for diagnosis and treatment of mental health disorders not within the scope of practice of the PCP, as defined by MHC and Mental Health/Short Doyle.
- The PCP will provide for diagnostic tests and/or specialty consultation as necessary to determine the etiology of the developmental disability or delay.
- If the member is eligible for both CCS and RC, the first or primary referral will be to CCS if the diagnosis or treatment for the CCS eligible condition is the major concern.
- MHC may notify CCS and the RC simultaneously if both medical and early intervention services are necessary.

The Primary Care Practitioner's (PCPs) Responsibilities

The PCP is responsible for:

- Identifying infants and toddlers who are at risk or suspected of having a developmental disability or delay and administering appropriate screening or assessment measures
- Providing all medically necessary services, including diagnosis, specialty or subspecialty referral, and indicated therapy
- Referring children identified as needing developmental intervention services to the local Early Start Program
- Participating or consulting with staff of the local RC or LEA in the development of the IFSP

The PCP will directly submit a written referral to the RC or referrals to the LEAs, which will be routed through the RC for approval. If requested by the PCP, the Case Management Department for either MHC will assist with the referral process and coordination. The PCP will provide information as requested by the RC or LEA to assist in the referral process for example:

- Specific physical findings will include:
 - A comprehensive physical examination and assessment for congenital abnormalities and/or treatable medical conditions
 - A review of the mother's prenatal/perinatal course to identify bio-medical or environmental risk factors
 - Follow-up of newborn screening tests to assure normal values or initiate appropriate treatment
- Developmental screening:
 - Provide developmental and/or behavioral assessments
 - Detection of any sensory deficit
 - Detection of any early developmental problem of significant interest
- Primary preventive and pediatric care:
 - Periodic comprehensive physical examination
 - Anticipatory parental guidance - health education, injury prevention, etc.
 - Immunizations
 - Lead screening and hematocrit
 - Monitoring of nutrition status
- Diagnosis and, if possible, etiology:
 - Complete family history including prenatal course in genetics and genetic history
 - Comprehensive medical evaluation to determine underlying causes and any chromosome or metabolic tests performed
 - Referrals for special consultations

Referral Coordination with California Children Services

In situations where the member is eligible for both CCS and Early Start, the first or primary referral should be to CCS, if the diagnosis or treatment for the CCS eligible condition is the major concern. The PCP should notify CCS and the appropriate RC simultaneously when both medical and early intervention services are necessary.

Coordination of Care

Depending on plan affiliation, the Medical Case Manager and Medical Director are available to assist PCPs and families with the referral procedure to ensure their referral was completed successfully and services were activated. If a member was previously referred to or accepted into the Early Start Program, the Medical Case Manager assesses the case to determine if further case management services, including health education, are needed. The Medical Case Manager also contacts the parent/guardian for approval to discuss the member's care with a RC. If the parent/guardian approves the involvement of the RC, the Case Manager coordinates an Individual Family Service Plan (IFSP) with the RC's Case Manager and the PCP. The IFSP must be completed within forty five (45) days. The RC's system is able to provide guidance and follow-up on referrals to specialists.

Once the referral has been made, the PCP and Medical Case Manager will:

- Provide/refer for medically necessary therapy and/or equipment.
- Continue with medical management.
- Consult with and provide appropriate reports to the Early Intervention Team.
- Assist the client and/or family in following the IFSP recommendation.
- Transportation may be provided by MHC when an ambulance or special vehicle is needed.

Consent, Record Keeping, and Confidentiality

The member or parent/guardian of a minor will consent to any screening, assessment, or treatment. Results of any screening, assessment, or treatment will be recorded in the member's medical record.

- Documentation will be in compliance with MHC Policy and Procedure, regarding Collection/Use/Confidentiality and Release of Primary Health Care Information.
- Findings, recommendations, and response to recommendations will be recorded by the Provider/Practitioner in the member's medical record.
- All information and results of the health assessment of each member will be confidential and will not be released without the informed consent of the member or parent/guardian.
- Appropriate governmental agencies will have access to records without consent of the member or responsible adult, i.e. DHCS, DMHC, DHHS, etc.

Problem Resolution

Unresolved questions and conflicts concerning Early Start program eligibility, diagnostic testing, treatment plan, and associated benefits should be directed to either of the following:

Molina Healthcare of California
Attn: Medical Case Manager
200 Ocean Gate, Suite 100
Long Beach, CA 90802
(888) 665-4621
Fax (562) 499-6149

Manager,
DDS Prevention and Children Services Branch
Department of Developmental Services
1600 Ninth Street, Room 360
Sacramento, CA 95814
(916) 654-2773

The Case Manager and the Medical Director will coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is obtained. The Case Manager will pursue resolution at both the county and state levels.

DEVELOPMENTAL DISABILITY SERVICE AND REGIONAL CENTER COORDINATION

The California Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with mental retardation, cerebral palsy, epilepsy, and autism.

RCs are private, non-profit corporations under contract with the DDS. Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidents of developmental disabilities. Providers/Practitioners must provide eligible Medi-Cal members identified with, or suspected of having, developmental disabilities with all medically necessary and appropriate developmental screenings, primary preventive care, and diagnostic and treatment services. For members at risk of parenting a child with a developmental disability, MHC provides genetic counseling and other prenatal genetic services.

Eligibility Determination

The PCP will complete an intake and assessment for members three (3) years and over with, or suspected to have, a developmental disability. Children and adults will receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This medical evaluation may include, but not be limited to:

- Prenatal/Perinatal
- Developmental
- Family history
- Metabolic and chromosomal studies
- Specialty consultation as indicated

The PCP will coordinate the developmental, psychological, and psychiatric assessment as appropriate. Referral to the appropriate fee-for-services Provider/Practitioner will be made through the County Mental Health, Short Doyle process when indicated.

Prior to receiving services from a RC, a member must be determined eligible under one (1) of the following categories:

- **Developmental Disability:** “Developmental disability” means a disability that originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap. As defined by the Director of the DDS, in consultation with the Superintendent of Public Instruction, developmental disability includes mental retardation, cerebral palsy, epilepsy, and autism. This term also includes handicapping conditions found to be related closely to mental retardation or to required treatment similar to that required for mental retardation. It does not, however, include other handicapping conditions that are solely psychiatric disorders, solely learning disabilities, and/or, solely physical in nature.
- **Persons at Risk:** Preventive services may be provided to any potential parent determined to be at high risk of parenting a child with a developmental disability and, at the request of the parent/guardian, to any infant at high risk of becoming developmentally disabled.

Referral Process

The PCP may refer members to the RC who are in need of non-medical, home, and community based services such as:

- Training in skills for daily living
- Acquisition of skills and behavior
- Family support
- Day habilitation
- Respite care
- Residential care or assisted living

Members having, or suspected of having, a developmental disability may be referred to the RC nearest the member's place of residence. Referrals from the PCP should be directed to the Intake Coordinator at the RC and will include the reason for referral, the complete medical history and physical examination report with appropriate developmental screens, the results of developmental assessment/psychological evaluation, and other diagnostic tests as indicated.

When MHC and the Medical Director determine that a member is potentially eligible for a RC service, the Case Manager will contact the PCP or specialist to determine if the member and the family have been informed and have approved the referral or have been previously referred or accepted into a RC.

If a member was previously referred to or accepted into the RC, the Case Manager assesses each individual case to determine if further case management services are needed. If services are not required, MHC contacts the parent/guardian for approval to discuss the member's case with the RC. At parent/guardian request, the Case Manager may coordinate the individual's Family Service Plan with the RC's Case Manager. If the member was not previously referred to or accepted into the RC, the Case Manager contacts the PCP and the family regarding assistance with the referral process. If requested, the Case Manager assists the family and Provider/Practitioner to complete the referral process.

Intake and Assessment

The RC must accept for evaluation an eligibility assessment of persons believed to have a developmental disability. The initial intake must be performed within fifteen (15) working days following a request for assistance. Assessments must be performed within one hundred twenty (120) working days or within sixty (60) days if delay in initiating services were to seriously impact mental or physical development.

Determination of RC eligibility is the responsibility of the RC Interdisciplinary Team. As mandated by Title 17, chapter 3, subchapter 1, article 54001, the Interdisciplinary Team must include the Service Coordinator, a Provider/Practitioner, and a psychologist. The assessment process includes collection and review of available medical history, diagnostic data, the provision or procurement of necessary tests and evaluations, and a summary of developmental/intellectual and adaptive levels of functioning as well as service needs.

PCPs must assist the RCs in obtaining medical records, diagnostic tests, and specialty consultations, as needed, to aid in a complete diagnosis. If the member is not accepted into the RC, the Case Manager from MHC or its affiliated health plan will confer with the referring Provider/Practitioner and the family and coordinate the referral for problem resolution.

Primary Care Practitioner's Responsibilities

PCPs will ensure the appropriate referral of children over thirty six (36) months and adults suspected of having disabilities to the appropriate local RC when requested by the individual and his/her parents, if a minor. The member's disability must manifest before he or she attains 18 years, show signs of continuing indefinitely, and constitute a substantial handicap. The PCP may request assistance from MHC in making referrals. The PCP will be directed to the RC's Intake Coordinator and his/her referral will include the following information:

- Reason for referral.
- Complete medical history and physical examination report, including appropriate developmental screens.
- The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.

Referrals

Referral to the RC will be made by the PCP directly. At PCP's request, MHC's Case Management Department will assist with the referral process. The referral will be made to the RC located nearest the member's place of residence. The RC service for various regions is included for your reference.

The PCP will complete an Intake and Assessment for members three (3) years or over having, or suspected of having, a developmental disability:

- Children and adults will receive a complete medical evaluation to confirm the diagnosis and to determine the genetic and/or non-genetic etiology. This evaluation should include, but need not be limited to:
 - Prenatal/perinatal
 - Developmental
 - Family history
 - Metabolic and Chromosomal Studies
 - Specialty Consultation as indicated
- The PCP will coordinate the developmental, psychological, and psychiatric assessment as appropriate. Referral to the appropriate fee-for-service Provider/Practitioner will be made through County Mental Health, Short Doyle process.
- The PCP will refer members to the RC who are in need of non-medical, home and community based services such as:
 - Training in skills for daily living
 - Acquisition of skills and behavior
 - Family support
 - Day habilitation
 - Respite Care
 - Residential care or assisted living
- The PCP will ensure the appropriate referral of children over thirty six (36) months and adults suspected of having disabilities to the appropriate local RC when requested by the individual, or his/her parents if a minor.
- The member's disability must manifest before he/she attains 18 years, show signs of continuing indefinitely, and constitute a substantial handicap.
- The referral will be made by the PCP to the RC located nearest the member's place of residence.

- RCs will review referrals to determine RC eligibility and consider the need for development programs or family support services which are not available from other generic or private information.
- The PCP will be directed to the RC's Intake Coordinator and his/her referral will include the following information:
 - Reason for referral.
 - Complete medical history and physical examination report, including appropriate developmental screens.
 - The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.

The RC will see the referral within fifteen (15) working days of receipt and the evaluation will be completed within one hundred twenty (120) calendar days thereafter. The RC is to notify the MHC PCP within one hundred twenty (120) days after the referral of member's eligibility.

On-going services for persons with developmental disabilities include developmental screening with vision and hearing assessments and review of dental status at intervals specified in the CHDP for children under age 21.

Referral Coordination with California Children Services

In situations where the child is eligible for both California Children Services (CCS) and RC services, the first referral should be to CCS if diagnosis or treatment for CCS eligible conditions is the major concern. The Provider/Practitioner may wish to notify CCS and the appropriate RC simultaneously if both medical and early intervention services are necessary.

Regional Center Responsibilities

The RC will see the referral within fifteen (15) working days of receipt and the evaluation will be completed within one hundred twenty (120) calendar days thereafter. The RC is to notify the PCP within one hundred twenty (120) days after the referral of the member's eligibility.

RCs do not have the responsibility for the provision of direct medical or health care services, but do provide overall case management for their clients, assuring access to health, developmental, social, and educational services from birth throughout the life of individuals who have a developmental disability. This benefit includes diagnostic services, counseling, client and family support, including family respite, and access to intervention and rehabilitation programs. RC staff will, as part of service coordination, undertake the following activities:

- Assist the client and/or family in following the recommendations of the health plan.
- Provide the necessary non-medical work or supportive services required in the client's individual program plans that are not available under the Medi-Cal Scope of Benefits.
- Provide consultation and share staff expertise regarding treatment and care of persons with developmental disabilities.

Case Management

- MHC will provide case management, i.e. coordinating services with primary care practitioners, specialists, and allied health professionals (including speech, occupation and physical therapists), procuring of durable and non-durable medical equipment (such

as - but not limited to - suction, ventilators, nebulizers, wheelchairs, lifts, ostomy care, incontinent supplies), and securing in-home nursing services and EPSDT supplemental services, unless CCS assumes responsibility for the case.

- When needed medical sub-specialty services are not available within the network, the service will be provided out-of-network, with the continuity of care maintained.
- With the written consent of the member or parent/guardian of a minor, medical records will be routed to the RC when appropriate.
- Case Management will provide follow-up and coordination of the treatment plan between the MHC PCP, any specialists, and the RC.

Case Management includes the following:

- For members 36 months to adults, providing or arranging for medically necessary diagnostic and treatment services necessary to correct and/or ameliorate conditions discovered in the screening process, in accordance with MMCD Policy Letter 97-03.
- Providing available medical documentation and reports, as requested, to the RC Case Manager.
- Providing or arranging for medically necessary therapies and durable medical equipment.

Transportation

MHC will provide transportation when ambulance or special vehicle is needed to accommodate equipment. Assistance with arrangement for transportation will be available through the health plan Member Services Department. Transportation will be provided when the care needed is of such nature that its continuity must be assured. The type of transportation will be determined by the need of the member.

Community Resources

The PCP will be responsible for referring children and adults having, or suspected of having, developmental disabilities to the RC. Community resources include, but are not be limited to:

- Training in skills for daily living (ADL)
- Acquisition of skills and behavior
- Family support
- Day habilitation
- Respite care
- Residential care or assisted living

Unresolved Questions and Conflicts

RC staff determines eligibility and provides case management services to their clients. Issues that arise between the RC and MHC, or the PCP will be resolved by MHC's Medical Director or the Medical Director of the affiliated health plan. During any problematic periods, a Case Manager and the PCP or specialty practitioner will continue to manage the medical case of the member. Medical Case Managers will maintain routine interaction with the RC and will share data regarding health care encounters and program enrollment figures.

Unresolved questions and conflicts between MHC and RC concerning eligibility, diagnostic testing, treatment plan, and associated member benefits, should be directed to either of the following:

Molina Healthcare of California
Attn: Medical Case Manager
200 Oceangate, Suite 100

Long Beach, CA 90802
(888) 665-4621
Fax (562) 499-6149

Manager,
DDS Prevention and Children Services Branch
Department of Developmental Services

1600 Ninth Street, Room 360
Sacramento, CA 95814
(916) 654-2773

The MHC Case Manager and Medical Director will coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is obtained. Included for your reference is the RCs Information Sheet and Roster.

CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES

Regional Centers

The Department of Developmental Services (DDS) is responsible for coordinating a wide array of services for California residents with developmental disabilities, infants at high-risk for developmental disabilities, and individuals at high risk for parenting a child with a disability. These services are, provided through a statewide system of twenty (20) locally based RCs.

The DDS contracts with the RCs to offer services in all fifty eight (58) California counties. Located throughout the state, the local RCs serve as the point of entry into the developmental mental disabilities service system including admissions to the developmental centers. The RCs provide intake and assessment services to determine client eligibility and service needs. RCs then work with other agencies and utilize “generic services” whenever possible to arrange purchase and provide services including the full range of early intervention services. Early intervention services that cannot be provided by other publicly funded agencies are generally purchased through contracts with service Providers/Practitioners that are “vendored” by a RC. Services vary among the RCs based on local needs and resources.

With the implementation of Part H and California’s Early Start Program, MMCD letter 97-02, the RCs share primary responsibility with the Special Education Local Plan Areas (SELPA) for the coordination and provision of early intervention services at the local level RCs and SELPA are responsible for coordination with other agencies and organizations, as needed, in the evaluation/assessment process and in the development of Individualized Family Services Plans (IFSPs) for those children eligible for early intervention services. The local RC can provide specific information on the services available in your community. As of February 28, 2012, California has twenty-one (21) regional centers with over forty (40) offices located throughout the state that serve individuals with developmental disabilities and their families.

REGIONAL CENTERS	DIRECTOR	AREAS SERVED
<u>Alta California</u> 2241 Harvard St., Ste. 100 Sacramento, CA 95815	Phil Bonnet (916) 978-6400	Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties

REGIONAL CENTERS	DIRECTOR	AREAS SERVED
<u>Central Valley</u> 4615 North Marty Ave. Fresno, CA 93722	Robert Riddick (559) 276-4300	Fresno, Kings, Madera, Mariposa, Merced, and Tulare counties
<u>East Bay</u> 500 Davis St., Ste. 100 San Leandro, CA 94577	James M. Burton (510) 618-6100	Alameda and Contra Costa counties
<u>Eastern Los Angeles</u> 1000 South Fremont Alhambra, CA 91802 Mailing: P.O. Box 7916 Alhambra, CA 91802	Gloria Wong (626) 299-4700	Eastern Los Angeles county including the communities of Alhambra and Whittier
<u>Far Northern</u> 1900 Churn Creek Rd., #319 Redding, CA 96002 Mailing: P. O. Box 492418 Redding, CA 96049	Laura Larson (530) 222-4791	Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, and Trinity counties
<u>Frank D. Lanterman</u> 3303 Wilshire Blvd., Ste. 700 Los Angeles, CA 90010	Diane Campbell Anand (213) 383-1300	Central Los Angeles county including Burbank, Glendale, and Pasadena
<u>Golden Gate</u> 875 Stevenson St., 6 th Floor San Francisco, CA 94103	James Shorter (415) 546-9222	Marin, San Francisco, and San Mateo counties
<u>Harbor</u> 21231 Hawthorne Blvd. Torrance, CA 90503	Patricia Del Monico (310) 540-1711	Southern Los Angeles county including Bellflower, Harbor, Long Beach, and Torrance
<u>Inland</u> 1365 S. Waterman Ave. San Bernardino, CA 92408 Mailing: P. O. Box 19037 San Bernardino, CA 92423	Carol Fitzgibbons (909) 890-3000	Riverside and San Bernardino counties
<u>Kern</u> 3200 North Sillect Ave. Bakersfield, CA 93308	Duane Law (661) 327-8531	Inyo, Kern, and Mono counties
<u>North Bay</u> 10 Executive Ct., Ste. A Napa, CA 94558	Bob Hamilton (707) 256-1100	Napa, Solano, and Sonoma counties
<u>North LA County</u> 15400 Sherman Way, Ste.170 Van Nuys, CA 91406	George Stevens (818) 778-1900	Northern Los Angeles county including San Fernando and Antelope Valleys

REGIONAL CENTERS	DIRECTOR	AREAS SERVED
<u>Orange County</u> 1525 North Tustin Ave. Santa Ana, CA 92705	Larry Landauer (714) 796-5100	Orange county
<u>Redwood Coast</u> 525 Second St., Ste. 300 Eureka, CA 95501	Clay Jones (707) 445-0893	Del Norte, Humboldt, Mendocino, and Lake counties
<u>San Andreas</u> 300 Orchard City Dr, Ste.170 Campbell, CA 95008	Santi J. Rogers (408) 374-9960	Monterey, San Benito, Santa Clara, and Santa Cruz counties
<u>San Diego</u> 4355 Ruffin Rd., Ste. 200 San Diego, CA 92123	Carlos Flores (858) 576-2996	Imperial and San Diego counties
<u>San Gabriel/Pomona</u> 761 Corporate Center Dr. Pomona, CA 91768	R. Keith Penman (909) 620-7722	Eastern Los Angeles county including El Monte, Monrovia, Pomona, and Glendora
<u>South Central LA</u> 650 W. Adams Blvd., Ste.200 Los Angeles, CA 90007	Dexter Henderson (213) 744-7000	Southern Los Angeles county including the communities of Compton and Gardena
<u>Tri-Counties</u> 520 East Montecito St. Santa Barbara, CA 93103	Omar Noorzad, Ph.D. (805) 962-7881	San Luis Obispo, Santa Barbara, and Ventura counties
<u>Valley Mountain</u> 702 North Aurora St. Stockton, CA 95202	Paul Billodeau (209) 473-0951	Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne counties
<u>Westside</u> 5901 Green Valley Cir, Ste. 320 Culver City, CA 90230-6953	Michael Danneker (310) 258-4000	Western Los Angeles county including the communities of Culver City, Inglewood, and Santa Monica

7.4 HEALTHCARE SERVICES: WAIVER PROGRAMS

DEVELOPMENTAL DISABILITIES SERVICES WAIVER

The Developmental Disabilities Services (DDS) administered Home and Community Based Services (HCBS) waiver program was established to meet the medical needs of developmentally disabled Medi-Cal recipients age 36 months to adults. DDS includes members with a disability that originates before the member attains 18 years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. DDS and MHC coordinate the medical management of chronically ill, developmentally disabled Medi-Cal members, including those with catastrophic illnesses, technologically dependent and/or risk of life threatening incidences, who, but for the provision of such services, would reside in an intermediate care facility for the developmentally disabled.

DDS HCBS Waiver Program

Regional Centers (RCs) oversee the DDS administered HCBS waiver program. There are four (4) types of care settings in the HCBS waiver program:

- Member's home where specialized services may be delivered
- Local intermediate care facility licensed as an ICS/DD
- Local habilitative developmental-disability care facility licensed as a DDH
- Local nursing developmental-care facility licensed as a DDN

The RC Inter-Disciplinary Team is responsible for determining the HCBS waiver setting most appropriate for the eligible member. Although the RCs provide overall case management, they are not responsible for the direct medical services. During the member's participation in the DDS administered waiver program, MHC will continue to provide all primary care and other medically necessary services.

Eligibility

MHC Case Management staff will monitor and review all inpatient stays to determine appropriate utilization and to identify members who may potentially benefit from a DDS HCBS waiver. Case Managers will also work to ensure that potentially eligible members are referred in a timely manner. Included for your reference is the DHCS assigned waiver criteria.

Referrals to HCBS

When a Case Manager is notified of a member with a potential need for supportive care, the Case Manager will initiate a request for the medical record from the member's Primary Care Practitioner (PCP). Upon receipt of the member's medical records, the Case Manager and the Medical Director will review the records to determine if there is a need for supportive care. If supportive care is not needed, no referral is made and the member or family is notified.

If supportive care is deemed necessary, a case conference will be conducted with the member and/or family, PCP, specialist, ancillary Providers/Practitioners, and MHC Case Manager. The MHC Case Manager is responsible for coordinating with the RC Case Manager and the PCP.

Referral and Coordination of Services

Once a member is deemed eligible for the DDS administered HCBS program, a RC Case Manager is assigned to coordinate waiver services. The receiving of DDS administered HCBS services does not warrant or require a member's disenrollment from the Plan.

PCP's Responsibilities

The PCP's primary responsibility is to refer members, transmit medical records, and develop a plan of treatment. The PCP, along with the Case Manager as necessary, is still required to provide and coordinate care.

The Case Manager is responsible for coordinating with the RC Case Manager and the PCP in the development of the member's individual services plan/individual education plan.

If the member is receiving services through DDS, the Case Manager assists in coordinating care with the PCP and RC. If the member is not receiving services through DDS, the Case Manager conducts an analysis of the cost-effectiveness of in-home services versus institutional services:

- If the member's condition meet criteria for the waiver program, the Case Manager makes an appropriate referral to DDS at:
 - Department of Developmental Services
 - Department of Health Care Services
 - 1600 9th Street
 - P.O. Box 944202
 - Sacramento, CA 94244-2020
 - (916) 654-1690
- If the member does not meet the criteria for the waiver program, or if placement is not available, MHC will continue to case manage and provide all medically necessary services to the member

Problem Resolution

RC's staff determines eligibility and is responsible for the overall case management of the member. In the event that MHC is in disagreement with the RC's decision and/or recommendation concerning the provision of waiver services, the Case Manager will be responsible for problem resolution. The Case Manager will continue to coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is reached.

WAIVER PROGRAMS - DEVELOPMENTAL DISABILITIES

DDS HCBS Waiver Participants

Administered by the Department of Developmental Services

- A recipient may only receive waiver services from the DDS HCBS
- A recipient may receive Medi-Cal benefits if "medically necessary"
- A recipient may receive Supplemental EPSDT benefits
- A recipient of waiver services must meet the criteria for participation in the waiver program AND meet the criteria for medical necessity

- The determinations of eligibility for participation in the DDS HCBS waiver are made by the RC
- The determinations of necessity of services are made by the RC Interdisciplinary Team using their person-centered planning process
- If the member has a qualifying condition or diagnosis under the Developmental Disabilities Program for the Waiver Programs and the member is over age 21, the MHC Case Management Department will evaluate eligibility for other programs
- Children with diagnosis of developmental delay are not eligible for the DDS HCBS waiver
- Children at risk of developing a developmental disability are not eligible for the DDS HCBS waiver
- The member must be a consumer of the RC and the RC will be contacted to provide oversight
- The member must meet the admission requirements for an ICF/DD, ICF/DD-H, or ICF/DD-N facility and require some medical care and active treatment
- The member must be a Medi-Cal beneficiary

Institutional DDS HCBS Waiver Participants

- The member must meet all criteria for DDS HCBS waiver program
- The member must have been determined eligible for DDS HCBS waiver services
- The member must receive a referral from the RC to the County for Medi-Cal fiscal eligibility determination using institutional rules
- The member must receive at least one (1) DDS HCBS waiver service at all times in order to maintain Medi-Cal eligibility

AIDS WAIVER PROGRAM

The AIDS Waiver Program is designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

Eligibility

To qualify for enrollment in the AIDS Waiver Program, members with Acquired Immune Deficiency Syndrome (AIDS) or symptomatic Human Immunodeficiency Virus (HIV) disease must meet the following criteria:

- Be Medi-Cal eligible
- Require nursing facility (NF) level of care or above
- Score sixty (60) or less on the Kamofsky Scale
- Have exhausted other coverage for health care benefits similar to those available under the AIDS waiver prior to utilization of AIDS waiver services
- Have a safe home setting

For children, waiver agencies must choose the Centers for Disease Control and Prevention “Classification System for Human Immunodeficiency Virus Infection in Children under 13 Years of Age.” Children must be classified as “P2” under the CVC classification to be eligible for the waiver program.

The PCP, with assistance from the Case Management staff, as requested, will inform eligible members about the availability of the AIDS Waiver Program. At the request of a member, the PCP will provide the Waiver Agency with appropriate medical documentation including:

- History and physical
- Relevant lab results
- Therapeutic regime

Information and documentation will be submitted for acceptance to:

Office of AIDS, California Department of Public Health (CDPH)
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426
(916) 449-5900
(916) 449-5909

Case Management and Coordination Process

Once MHC Case Management Staff is notified of a member with a potential need for supportive care, staff requests medical records from the member's PCP. Case Management Staff, with the PCP, meets with the member and caregivers to discuss AIDS Waiver Program availability:

- If the member is eligible for and requests program referral, the type of supportive care needed is identified and a referral is initiated by the Case Manager
- If the member is determined to be ineligible or declines program referral, the Case Manager initiates case management as necessary

The Case Manager coordinates the transfer of the case management plan and/or any pertinent information to the AIDS Waiver Program representative. Financial limitations of the program are provided on a yearly basis per patient per calendar year. The carve-out of AIDS medications is included for your reference.

Problem Resolution

Resolution of problems or conflicts between the HIV/AIDS provider/practitioner and Office of AIDS can be addressed to either of the following:

Molina Healthcare of California
Attn: Medical Director
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196

Office of AIDS
California Department of Public Health
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426
(916) 449-5900
(916) 449-5909 (fax)

HOME AND COMMUNITY-BASED SERVICES

The Home and Community Based Services (HCBS) are designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

The medical management of chronically ill members, including members with catastrophic illnesses, technologically dependent and/or risk of life threatening incidences; require close coordination between MHC, its subcontracted Providers/Practitioners, and the In-Home Operations (IHO) administered HCBS waiver program. The primary goal is to ensure that the medical needs of members who are physically, and possibly mentally, disabled are met appropriately and safely in a home environment.

- In-Home Medical Care (IHMC) Waiver - The IHMC Waiver is designed for Medi-Cal recipients who, in the absence of the waiver, would be expected to require at least ninety (90) days of acute hospital care before beginning IHMC Waiver services
- Skilled Nursing Facility (SNF) - The SNF Waiver is designed for persons who are physically disabled or aged at the NF Level B SNF level of care and who are inpatients of an NF Level B, or whose admission to an NF Level B is imminent

Referral and Coordination Process

MHC staff will monitor and review all in-patient stays to determine appropriate utilization and to identify members who may potentially benefit from an HCBS waiver. The MHC staff will review the potentially eligible member's medical needs and prognosis for ongoing care with the PCP and Inpatient Facility Discharge Planner/Case Manager.

The PCP will inform the member, guardian, or authorized representative about the availability of in-home care alternatives. Such education will be documented in the member's medical record. On consent of the member, guardian, or authorized representative, the MHC staff will coordinate with the Inpatient Facility Discharge Planner/Case Manager to refer the member to a licensed and Medi-Cal certified Home Health Agency for evaluation.

The Home Health Agency Multi-Disciplinary Team will evaluate the member's health care needs and the appropriateness of the member's home and health environment. In coordination with the hospital staff, MHC's Case Manager will request an interdisciplinary care team conference. Attendees will include the member and/or family caregivers, PCP and/or attending Provider/Practitioner, Inpatient Facility Discharge Planner, Case Manager, and the Home Health Agency Case Manager. The purpose of this conference is to assess the feasibility of in-home care, to recommend the appropriate services necessary to meet the health care needs of the member and to predict a potential start date for in-home care.

Authorization

The Home Health Agency will prepare all necessary Letters of Agreement and the Treatment Authorization Request (TAR). Home Health Agencies are encouraged to identify the waiver recipient by highlighting "waiver recipient" in the Provider/Practitioner address section of the TAR. The Home Health Agency will submit the appropriate information to the following:

For programs administered by In-Home Operations, including Nursing Facilities Waiver and In-Home Medi-Cal Waiver, appropriate information should be submitted to:

Senior and Adult In-Home Supportive Services
4875 Broadway Sacramento, CA 95820
Telephone: (916) 874-9471
Fax: (916) 874-9682

If the agency administering the waiver program concurs with MHC's assessment of the member and there is available placement in the waiver program, the member will receive waiver services

while still being enrolled with MHC. MHC shall continue to provide all medically necessary covered services to the member.

Problem Resolution

In the event of a disagreement with the Authorizing Unit decision and/or recommendations concerning the provision of waiver services, MHC's Case Manager will be responsible for initiating the problem resolution process.

The Authorizing Unit Staff determines eligibility and the Home Health Agency Case Manager is responsible for the overall case management of the member. If prior to disenrollment from MHC, a participating Provider/Practitioner disagrees with an Authorizing Unit's decision regarding eligibility or the Home Health Agency's Case Manager's service provisions, all medical records and correspondences will be forwarded to the MHC Medical Director at:

Molina Healthcare of California
Attn: Medical Director
200 Oceangate, Suite 100
Long Beach, CA 90802
Telephone: (800) 526-8196
Fax: (562) 499-6173

The MHC Case Management Department will continue to coordinate with the MHC Medical Director to authorize all immediate health care needs for the member in collaboration with the PCP until resolution is obtained. The Authorizing Unit Staff will forward issues to MHC's Medical Director for resolution at the County and State level.

NURSING FACILITY WAIVER PROGRAM

Criteria for Nursing Facility (NF) Waiver Program

Administered by In-Home Operations

- The beneficiary for whom in-home medical care waiver services are requested would otherwise require care in an inpatient acute care hospital for at least ninety (90) consecutive days
- The total cost incurred by the Medi-Cal program in providing in-home medical care waiver services and other medically necessary Medi-Cal services to the beneficiary is less than the total cost incurred by the Medi-Cal program in providing all medically necessary services to the beneficiary in an inpatient acute care hospital
- Case Management services that are provided by a licensed Registered Nurse (RN) consist of ongoing inpatient assessment, evaluation, routine case recording, and preparation of reports to PCP and Medi-Cal regional offices
- Nursing care is provided by a certified individual supervised by an RN or Licensed Vocational Nurse (LVN)
- Those physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual or to enable the recipient to function with greater independence in the home and without which the recipient would require institutionalization. The service is a one (1) time event as required by the recipient's plan of care
- Care consists of duties identified by the Board of Registered Nursing to be performed by RNs only, as defined in Title 22, C.C.R., Section 51067

- Care provided by a licensed individual as defined under Title 22, C.C.R., Section 51069
- A Personal Emergency Response System (PERS) is an electronic device which enables individuals at high-risk of institutionalization to secure help in the event of an emergency
- Family training is provided by a licensed RN for the families of individuals served under this waiver. Training includes instruction about treatment regimens and use of equipment specified in the plan of care and will include updates as necessary to safely maintain the individual at home
- Physical Therapy services will include evaluation, treatment planning, treatment, instruction, consultation services, and treatment of any bodily condition by the use of physical, chemical, and other properties of heat, light, water, electricity or sound, and by massage and active, resistive, or passive exercise. Single procedure to one (1) resistive or passive exercise. Single procedure to one (1) area - initial thirty (30) minutes
- Occupational Therapy - services prescribed by a Provider/Practitioner to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness, or advanced age. Occupational Therapy services will include evaluation, treatment planning, instruction, and consultation services. Treatment - initial thirty (30) minutes with additional treatment of fifteen (15) minutes each
- Speech Therapy services - speech language therapy per one-half (1/2) hour
- Audiology services are services for the purpose of identification, measurement, appraisal, and counseling related to hearing and disorders of hearing, the modification of communicative disorders resulting from hearing loss affecting speech, language and audiological behavior, and the recommendation and evaluation of hearing aids. Hearing Therapy per one-half (1/2) hour
- Family Therapy is a service in which appropriate assessments are made by a qualified counselor to the recipient, as well as group and family counseling with the recipient, with regard to the psychological adjustment to home and community-based care. One (1) and one-half (1/2) hours maximum
- Utility services directly attributable to the operation of life-sustaining medical equipment in the recipient's place of residence to prevent re-institutionalization of waiver recipients who are dependent upon medical technology for survival in or out of an institution. Utility coverage must be included in the plan of care
- Shared nursing services provided to two (2) or more recipients by a licensed RN, in accordance with the plan of care
- Shared nursing services to two (2) or more recipients by a licensed LVN under the direction of an RN, in accordance with the plan of care
- Shared nursing services provided to two (2) or more recipients by a licensed Home Health Aide under the direction of an RN in accordance with the plan of care
- Unspecified waiver services to be used for unlisted NF waiver services
- Members do not need to disenroll from MHC while they are enrolled in the Nursing Facility/Acute Hospital Waiver (NF/AH Waiver) Program.

Criteria for Pediatric Sub-Acute

- Tracheostomy care with continuous mechanical ventilation for a minimum of six (6) hours each day
- Tracheostomy care with suctioning and room air or oxygen as needed and one (1) of the six (6) treatment procedures listed below
- Administration of any three (3) of the six (6) treatment procedures listed below

Treatment Procedures

- Total parenteral nutrition
- Inpatient physical, occupational, and/or speech therapy, at least two (2) hours per day, five (5) days per week
- Tube feeding (nasogastric or gastrostomy)
- Inhalation therapy treatments every shift at a minimum of four (4) times per twenty four (24) hour period
- IV therapy involving:
 - The continuous administration of a therapeutic agent
 - The need for hydration
 - Frequent intermittent IV drug administration via a peripheral and/or central line
- Dependence on peritoneal dialysis treatments requiring at least four (4) exchanges every twenty four (24) hours

ADULT SUB-ACUTE

Criteria are based on: Milliman and Robertson: Alternative Setting Criteria.

IN-HOME MEDICAL WAIVER

Criteria for In-Home Medical Waiver

Administered by the In-Home Operations

- The attending Provider/Practitioner and Medical Director or designee has determined that the patient requires the acute level of care
- The attending Provider/Practitioner takes total responsibility for the care of the patient
- The patient's condition is chronic and requires long-term care. The patient is relatively stabilized so as to make in-home care safe and feasible
- The home setting is medically appropriate as determined by the Medical Director or designee
- A supportive home and/or community environment makes home placement possible
- The cost of home and community-based care is less than the cost of acute care for the individual and is the least costly care available and is appropriate for the individual

MULTIPURPOSE SENIOR SERVICES PROGRAM

Multipurpose Senior Services Program (MSSP) provides social and health care management for frail elders who are eligible for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

MSSP assists frail, elderly members, sixty five (65) years and over and at-risk of nursing home placement, to remain safely in their homes. MHC members may be eligible for MSSP if they are 65 years of age or older, live within an MSSP site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement.

MSSP services include:

- Adult day care
- Housing assistance
- Chore and personal care assistance
- Protective supervision
- Care management
- Respite
- Transportation
- Meal services
- Social services
- Communications services

Referral and Coordination Process

MHC Utilization Management staff monitors and reviews members to determine appropriate utilization of services and to identify members who may potentially benefit from the MSSP waiver program. It is the responsibility of the health plan to ensure that potentially eligible members are referred to the MSSP waiver program in a timely manner.

The health plan's Utilization Management staff and PCP shall work with the MSSP Waiver Case Management Team to coordinate appropriate services.

Once the Case Manager is notified of a member with a potential need for support or care, he/she initiates the request for medical records from the member's PCP. If MSSP care is not indicated, no referral is made and the member and/or family member is notified by the Case Manager and the PCP continues to case manage. If MSSP care is indicated, a case conference shall be conducted with the member and/or family, PCP, specialist, ancillary Provider/Practitioners, and Case Manager. The case conference is coordinated by the MSSP Case Management Team.

Case Management Process

If the member is determined to be eligible for program referral to the MSSP, MHC or affiliated subcontracted plan Case Manager shall actively participate in the MSSP Case Management Team to develop a comprehensive case management plan. The Case Manager will assist the MSSP team to ensure timely, effective, and efficiently coordinated services to meet the member's care plan goals.

Problems and Resolutions

In the event that there is a disagreement with the MSSP decision and/or recommendations concerning the provision of waiver services, MHC Case Management staff will be responsible for problem resolution. Problem resolution will be coordinated through the Department of Aging, the DHCS, as listed above, and in collaboration with the MHC Medical Director.

COMMUNITY BASED ADULT SERVICES (CBAS)

Licensed Community Based Adult Services (CBAS) Centers provide health and social services as an alternative to institutionalization and a safe and therapeutic environment for adult MHC members with eligible conditions.

As of October 1, 2012, MHC became financially responsible for all CBAS services; however, the Primary Care Practitioner (PCP) continues to be responsible for providing medically necessary care. CBAS includes nursing and therapeutic care for the member who may have a physical or mental impairment that handicaps daily activities but who does not require institutionalization.

Eligibility

Members that have physical or mental impairments, occurring after age 18, that adversely affect the performance of daily activities, may be eligible for CBAS. Sample diagnoses which may be eligible for CBAS include, but are not limited to:

- Disorders which cause dementia such as Alzheimer's or multi-infarct disease, cerebral vascular conditions such as strokes or aneurysms, degenerative diseases that cause both physical and cognitive impairment, brain injury due to trauma or infection, brain tumors, Human Immunodeficiency Virus (HIV) related dementia, diabetes, hypertension, ulcers, cardiovascular disease or cerebral vascular disease

Referral

Referrals to a CBAS center may be made as a self-referral, by the member's family/ care giver or by the PCP. Coordination may be done by a multi-disciplinary team approach by the CBAS center with the PCP and the appropriate health plan HCS staff prior to acceptance to the center.

Referral process includes the following:

- Member is referred to the Community Based Adult Service center;
- The CBAS center obtains medical history, current status and recommendations for service from the PCP;
- The CBAS center completes an initial intake survey and sends a CBAS Service Request to MHC's Utilization Management Department;
- MHC determines eligibility for CBAS services using the State provided CBAS Eligibility Determination Tool (CEDT) within 30 calendar days of the receipt of the request;
- If the Member meets eligibility determination to receive CBAS services, MHC's HCS staff refers the Member to the CBAS center for Individual Plan of Care (IPC) and Level of Service (LOS) recommendations;
- The CBAS center's Multi-Disciplinary Team (MDT) (including but not limited to, the Registered Nurse, social worker, and therapist) performs the MDT assessment;
- The CBAS center completes the CBAS Service Requests with IPC and LOS recommendations and sends to MHC;
- MHC's HCS staff adjudicates the prior authorization request with IPC & Level of Service recommendation within five (5) days for standard review and three (3) days for an expedited review;
- After discussion with and approval of MHC, the Member begins CBAS services.

PCP's Responsibility

The PCP is responsible for:

- Identifying the members specific care needs
- Informing the members of their eligibility for these services
- Referring appropriately
- Requesting appropriate case management for services when indicated
- Rendering appropriate medical care and/or referral follow-up for medical problems identified by Providers/Practitioners
- Participating in the MDT coordinated by the MHC's Case Management

The PCP is responsible for conferring with the appropriate California Caregiver Resource Center and assisting the family and caregivers in accessing the appropriate service Providers/Practitioners. When a referral is made to a CBAS center, the PCP will include an approved plan of medical treatment and other pertinent medical information. This is completed when requested by the CBASC.

Caregiver Resource Centers

Serving as a state wide resource consultant:

Family Caregiver Alliance
Telephone: (800) 445-8106

Training and Education

- MHC's Provider Services Department will provide education to Providers/Practitioners regarding CBAS. Please contact the Provider Services Department at (888) 665-4621 if you require additional information regarding Community Based Adult Services.
- Providers/Practitioners may contact MHC's Case Management Department to receive information about CBAS services.
- Members are informed of their rights to access these services through the Evidence of Coverage (EOC) which is distributed to all members at the time of enrollment and annually thereafter.

Plan Responsibility

MHC is responsible for:

- Education of MHC Providers/Practitioners and Providers/Practitioner's staff of member eligibility for excluded services.
- Case Management services as identified for coordination of services.
- Oversight for appropriateness through the Quality Improvement Audit process.

CBAS Center's Responsibilities

- The referred CBAS center is responsible for submitting a treatment authorization request along with the IPC and LOS to MHC's Utilization Department for approval.
- CBAS center will follow requirements as defined in Title 22, CCR, Section 54001, 78000, et al.
- Each CBAS center will be licensed to provide Community Based Adult services.
- Each CBAS center will have an appropriate licensed allied health professional to provide services in accordance with Title 22.
- The CBAS center will be responsible for providing a multi-disciplinary team to meet the needs of the members.

Problem Resolution

If a problem should arise between MHC and the CBAS regarding mutual responsibilities, the health plan Case Manager will be notified of the problem. All medical records and correspondence will be forwarded to the MHC Case Management Department at:

Molina Healthcare of California
Case Management Department
200 OceanGate, Suite 100
Long Beach, CA 90802
Telephone: (888) 665-4621
Fax: (888) 273-1735

The Case Manager will:

- Issue related written correspondence to the appropriate CBAS center
- Investigate the issue of conflict
- Refer to the appropriate Medical Director for review
- Report review determinations to the CBAS center
- Communicate issues and determinations to the PCP and other involved parties

IN-HOME SUPPORTIVE SERVICES

In-Home Supportive Services (IHSS) is a California program that provides in-home care for members who cannot safely remain in their own homes without assistance. To qualify for IHSS, members must be over 65 years of age, or disabled, or blind and in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. By providing in-home assistance to low income aged and disabled individuals, the IHSS program prevents premature nursing home or board and care placement and allows people to remain safely in their own homes and communities.

IHSS is currently covered under the Medi-Cal benefit will be integrated/coordinated by Managed Care Plans like Molina. Molina Healthcare of California will coordinate IHSS benefits for eligible enrollees through county IHSS agencies. IHSS will remain an entitlement program. IHSS consumers' will continue to self-direct their care by hiring, firing, and managing their IHSS workers. County social services agencies will continue the IHSS assessment and authorization processes, including determining IHSS hours. The current fair hearing process for IHSS will remain during the initial years of the demonstration. Molina Healthcare of California will pay for IHSS hours for which an enrollee has been deemed eligible by the county IHSS agency.

Services included in IHSS include:

- Housecleaning
- Meal preparation and clean-up
- Laundry
- Grocery shopping and errands
- Personal care services (bowel/bladder care, bathing, paramedical service, etc.)
- Accompaniment to medical appointments
- Protective supervision for persons with cognitive or intellectual disabilities

One of the most noteworthy aspects of the IHSS program is the beneficiaries' ability to self-direct their care. Self-directed care is the process by which the IHSS consumer who is disabled, blind or

over the age of 65, and who meets the eligibility criteria for IHSS, chooses to hire, train, supervise, and if necessary fire the personal assistant. In situations where due to intellectual and/or cognitive deficits, Molina case managers will coordinate with county social workers to ensure that a public guardian or conservator can be appointed to provide oversight.

How to refer Molina Members in need of IHSS Services:

Providers needing to make a referral should call Member Services at (888) 665-4621 and request assistance in referring the member for IHSS and other community resources.

7.5 HEALTHCARE SERVICES: ALCOHOL & SUBSTANCE USE DISORDERS TREATMENT & SERVICES

ALCOHOL AND DRUG TREATMENT SERVICES

Drug Medi-Cal (D/MC), also referred to as Short-Doyle Medi-Cal (SD/MC), alcohol and drug treatment services are excluded from MHC's Medi-Cal Drug and Alcohol coverage responsibility under the Two-Plan Model Contract. Services are available under the SD/MC programs and through Heroin Detoxification Treatment Services. These services are provided through county operated SD/MC programs, or through direct contracting between the State Department of Alcohol and Drug Programs and community-based Providers/Practitioners.

MHC and subcontracted Providers/Practitioners coordinate referrals for members requiring specialty and inpatient clinical dependency/substance abuse treatment and services. Members receiving services under the SD/MC Program remain enrolled in MHC. Contracted PCPs are responsible for maintaining continuity of care for the member.

Alcohol and Drug Treatment Services

The alcohol and drug treatment services covered by the SD/MC programs include, but are not limited to:

- Outpatient methadone maintenance services
- Outpatient drug-free treatment services
- Daycare habilitative services
- Perinatal residential substance abuse services
- Naltrexone treatment services for opiate addiction

Members receiving alcohol and drug treatment services through the SD/MC program remain enrolled in MHC.

Referral Documentation

PCPs are responsible for performing all preliminary testing and procedures necessary to determine an appropriate diagnosis. Referrals to SD/MC and/or Fee-For-Service Medi-Cal (FFS/MC) Program should include the appropriate medical records supporting the diagnosis and the required demographic information. After eligibility is approved by the County FFS/MC and/or SD/MC Program, the member's PCP will submit the requested medical record to assist in the development of a comprehensive treatment plan. A final decision on acceptance of a member for FFS/MC and/or SD/MC services rests solely with the County Alcohol and Drug Program.

Criteria for Referral for Alcohol and/or Drug Treatment Services

The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health, and any request for such services from either the member or the member's family. Various screening tools are included in this Manual to assist the PCP in the detection of substance abuse.

Referral Process

- The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health, and request for such services from either the member or the member's family
- Once the determination has been made to refer the member for alcohol and drug treatment services to a Short-Doyle (SD) Provider/Practitioner or a Fee-For-Service (FFS) Provider/Practitioner, the PCP may make the referral directly or may refer the member to MHC or its affiliated health plan Medical Case Manager for the coordination of services and follow-up
- According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will conduct an authorization and review process to determine the appropriate level of care for the member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care and frequency of service
- When appropriate, the health plan Medical Case Manager coordinates with the MHC Member Services Department &/or Health Education Department to meet a member's cultural and linguistic needs.
- Providers/Practitioners seeking guidance in the provision of services to members with specific cultural needs are referred to the Health Education Department and the department will offer assistance
- Daycare Habilitative Services are reimbursable only if they are provided for pregnant or postpartum members and for Early and Periodic Screening, Diagnosis and Treatment-eligible Medi-Cal members
- SD/MC services within the five (5) treatment modalities referenced may be provided to a member and billed to the SD/MC program. No other additional treatment services may be authorized and paid within the SD/MC payment system

PCP's Responsibilities

- PCPs are responsible to act as the primary care practitioner for the member and to make referrals to medical specialists, as necessary
- The PCP is responsible for performing all preliminary testing and procedures necessary to determine diagnosis. Should the member require specialty service, the PCP will refer the member to the appropriate SD/MC alcohol and drug Provider/Practitioner
- The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition prompting the referral
- The PCP will assure that appropriate documentation is in the member's medical record.
- The PCP will screen and thoroughly assess the member for additional conditions that may directly or indirectly impact the treatment or care of the member
- PCPs are responsible for coordinating care and services for non-SD/MC related conditions, which may include problems and unmet health care needs directly and indirectly related to or affected by the member's addiction and lifestyle. This assessment may include medical conditions such as Acquired Immune Deficiency Syndrome (AIDS)/HIV, cirrhosis, tuberculosis, abscesses, sexually transmitted diseases, infections, lack of necessary immunizations, and/or poor nutrition. This assessment may also include psychiatric

disorders such as depression, bipolar disorder, and other anti-social personality disorders that contribute to repeating the cycle of addiction and substance abuse

Criteria for Inpatient Detoxification

A member will be considered a candidate for referral for acute inpatient detoxification if signs and symptoms are present that suggest the failure to use this level of treatment would be life threatening or cause permanent impairment once substance abuse is stopped. A member must have all of the following criteria for inpatient detoxification:

- Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions.
- Twenty-four (24) hour nursing care with close frequent observation/monitoring of vital signs.
- Medical therapy, which is supervised and re-evaluated daily, by the attending physician in order to stabilize the member’s physical condition.

The member must exhibit at least two (2) or more of the following symptoms for substance withdrawal:

- Tachycardia
- Hypertension
- Diaphoresis
- Significant increase or decrease in psychomotor activity
- Tremors
- Significantly disturbed sleep patterns
- Nausea/vomiting
- Clouding of consciousness with reduced capacity to shift, focus, and sustain attention

Additionally, criteria for inpatient alcohol detoxification are based on the anticipated severity of the withdrawal as deemed by application of the Revised Clinical Institute Withdrawal Assessment for Alcohol Scale. These tools should be applied as follows:

POINTS ON SCALE	SEVERITY OF WITHDRAWAL	TREATMENT
0 – 5	No withdrawal	Outpatient
6 – 9	Mild withdrawal	Outpatient
10 – 14	Mild-to-moderate withdrawal	Outpatient treatment possible for stable, withdrawal compliant patients with no medical or psychiatric complications and no concurrent abuse of other classes drugs. One (1) day of CHB could be authorized for observation with subsequent assignment either to DCI or outpatient treatment based on reapplication of CIWA-Ar
15 – 19	Moderate-to-severe withdrawal	Hospitalize for detox. Review CIWA-Ar after three (3) days for re-determination
15 with threatened delirium tremens or score of 20+	Severe withdrawal	Hospitalize for detox. Review CIWA-Ar after three (3) days for re-determination

Once the determination and authorization has been made to refer the member for alcohol and drug treatment services to a SD Provider/Practitioner or a FFS Provider/Practitioner, the PCP may make the referral directly, or may refer the member to the MHC Case Manager for the coordination of services and follow-up.

According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will review the case to determine the appropriate level of care for the member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care, and frequency of service.

Criteria for Admission to a Residential Facility for Treatment of Substance Abuse

A member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence that meets the current Diagnostic and Statistical Manual (DSM) criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities.
- The member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met.
- There is clearly documented evidence of the failure of appropriate partial hospitalization or structured outpatient treatment for substance abuse or dependence meeting the current DSM criteria.
- The member's environment or living situation is severely dysfunctional as a result of inadequate or unstable support systems, including the work environment, which may jeopardize successful treatment on an outpatient basis.
- There is significant risk of relapse if the member is treated in a less restrictive care setting related to severely impaired impulse control or a code-morbid disorder.

Criteria for Admission to a Partial Hospital Program for Treatment of Substance Abuse

A member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities.
- The member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met.
- The member requires up to eight (8) hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group or family therapy, education, and/or medical supervision.
- The member's environment or living situation and social support system are sufficiently stable to allow for treatment in this care setting.
- There is evidence of sufficient motivation for successful participation and treatment in this care setting.
- The member has demonstrated, or there is reason to believe, that the member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment, and pattern of use.

Criteria for Admission to a Structured Outpatient Program for Treatment of Substance Abuse

A Member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities.
- The member requires up to four (4) hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group, or family therapy, education, and/or medical supervision.
- The member's environment or living situation and social support system are sufficiently stable to allow for treatment in this care setting.
- There is evidence of sufficient motivation for successful participation in treatment in this care setting.
- The member has demonstrated, or there is reason to believe, that the member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment and pattern use.

Criteria for Inpatient Chemical Dependency Rehabilitation

A member will be considered a candidate for referral when a combination of the following conditions have been met:

- There is evidence of a substance dependence disorder as described in the DSMIV
- There is evidence of an inability to maintain abstinence outside of a controlled environment
- There is evidence of impairment in social, family, medical, and/or occupational functioning that necessitates skilled observation and care
- There is evidence of need for isolation from the substance of choice and from destructive home influences
- The member has sufficient mental capacities to comprehend and respond to the content of the treatment program

Continuity of Care

Providers/Practitioners should provide services in a manner that ensures coordinated and continuous care to all members requiring alcohol and/or drug treatment services including:

- Appropriate and timely referral
- Documenting referral services in the member's medical record
- Monitoring members with ongoing substance abuse
- Documenting emergent and urgent encounters, with appropriate follow-up, coordinated discharge planning, and post-discharge care in the member's medical record

Upon request, MHC Case Management staff will assist in the identification of cases that require coordination of social and health care services.

In the event that the local SD/MC treatment slots are unavailable, the PCP and MHC's Case Management's staff will pursue placement in out-of-network services until the time in-network services become available.

To assure continuity of care when a member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the member's medical record to the substance abuse Provider/Practitioner or program and, if appropriate, to the organization where future care will be rendered. Any transfer of member medical records and/or other pertinent information will be done in a manner consistent with confidentiality standards, including a release of medical records signed by the member.

Clinical needs and availability of follow-up care will be documented in the member's medical record. It is recommended that the member should be in contact with the follow-up therapist or agency prior to discharge from an inpatient facility or outpatient program.

It is expected that members discharged from a substance abuse inpatient unit will have their follow-up care arranged by the facility's discharge coordinator. MHC recommends that the initial outpatient follow-up appointment occur no later than thirty (30) days after discharge. In addition, the facility discharge coordinator is responsible for notifying the PCP of the member's impending discharge.

Confidentiality

- Confidential member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Confidential member information may be learned by a staff member, in either a casual or formal setting, including conversation, computer screen data, faxes, or any written form, all of which will be treated with strict confidence.
- MHC and affiliated health plan employees and contracting Providers/Practitioners and their staffs are expected to respect each member's right of confidentiality and to treat the member information in a respectful, professional, and confidential manner consistent with all applicable federal and state requirements. Discussion of member information will be limited to that which is necessary to perform the duties of the job.
- Applicable MHC policies and procedures include Collection/Confidentiality and Release of Primary Health Care Information and Safeguarding and Protecting Departmental Records.

Problem Resolution

If a disagreement occurs between MHC and the County Office of Alcohol and Drug Programs regarding responsibilities, the Utilization Management Department is notified of the problem. All medical records and correspondence should be forwarded to MHC at:

Molina Healthcare of California
Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196
(562) 901-9330 (fax)

The Utilization Management Department will:

- Review medical records for issue of discrepancy and discuss with the MHC's Medical Director
- Discuss with the State or County Mental Health Department Office of Alcohol and Drug Programs the discrepancy of authorization and the MHC Clinical Review
- Report MHC's review determination to the County Mental Health Department Office of Alcohol and Drug Programs
- Communicate State or County determinations to the PCP, MHC Medical Director, and other involved parties

Why Do We Need To Ask About Substance Abuse?

There are many forms of substance abuse that cause substantial risk or harm to the individual. They include excessive drinking each day, repeated episodes of drinking or using drugs to intoxication, drinking or using drugs that are actually causing physical or mental harm and that has resulted in the person becoming dependent or addicted to the substance being used to excess.

In a primary care practice survey, 15% of the patients had a high risk or dependent pattern of alcohol abuse and 5% had the same pattern with other drugs. Studies have shown that up to 25% of patients admitted to medical-surgical beds in hospitals either have dependence or abuse of alcohol or drugs. Substance-related disorders in the elderly remain overlooked and undertreated. Up to 16% of the elderly have alcohol use disorders. With Americans age 65 and older constituting the fastest growing segment of our population, this issue becomes increasingly important. Mortality from withdrawal increases with each additional medical condition a person has.

Screening Tools:

Included for your reference are the following:

- Red Flags for alcohol/drug abuse
- Questions to ask patients
- CAGE AID
- Drug use questionnaire (DAST-20)

RED FLAGS FOR ALCOHOL/DRUG ABUSE

Observable

1. Tremor/perspiring/tachycardia
2. Evidence of current intoxication
3. Prescription drug seeking behavior
4. Frequent falls; unexplained bruises
5. Diabetes, elevated BP, ulcers
6. Frequent hospitalizations
7. Inflamed, eroded nasal septum
8. Dilated pupils
9. Track marks/injection sites
10. Gunshot/knife wound
11. Suicide talk/attempt, depression
12. Pregnancy (screen all)

Laboratory

1. MCV - over 95
2. MCH - High
3. GGT - High
4. SGOT - High
5. Bilirubin - High
6. Triglycerides – High
7. Anemia
8. Positive UA for illicit drug use

CAGE-AID

The CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug abuse.

- Target population: Adults and adolescents
- Evidence:
 - Easy to administer, with good sensitivity and specificity (Leonardson et al. 2005)
 - More sensitive than original CAGE questionnaire for substance abuse (Brown & Rounds 1995)
 - Less biased in term of education, income, and sex than the original CAGE questionnaire (Brown & Rounds 1995)
- Scoring: Each question is scored one (1) point.
 - A score of 1 raises suspicion of alcohol or drug abuse.
 - A score of 2+ indicates likelihood of abuse, i.e. alcohol or drug use disorder.

CAGE-AID questions to ask patients:

1. Have you ever felt you should ***Cut Down*** on drinking or drug use?
2. Have people ***Annoyed*** you by criticizing or complaining about your drinking or drug use?
3. Have you ever felt bad or ***Guilty*** about your drinking or drug use?
4. Have you ever had a drink or drug in the morning (***Eye Opener***) to steady your nerves or to get rid of a hangover?
5. Do you use any drugs other than those prescribed by a practitioner?
6. Has a practitioner ever told you to cut down or quit use of alcohol or drugs?
7. Has your drinking/drug use caused family, job, or legal problems?
8. When drinking/using drugs have you ever had a memory loss (blackout)?

Opioid Dependence

Opioid dependence is characterized by a cluster of cognitive, behavioral and physiological features. International Classification of Diseases, 10th edition (ICD-10) identifies such features:

- A strong desire or sense of compulsion to take opioids
- Difficulties in controlling opioid use
- Physiological withdrawal state
- Tolerance Progressive neglect of alternative pleasures or interests because of opioid use
- Persisting with opioid use despite clear evidence of overtly harmful consequences

ICD-10 defines opioid dependence as the “presence of three or more [of these features] present simultaneously at any one time in the preceding year.” Opioid dependence can include both heroin and prescribed opioids. The criteria for dependence are the same whether the substance is heroin or prescribed pain medications.

Symptoms of opioid intoxication include drooping eyelids and constricted pupils, sedation, reduced respiratory rate, head nodding, and itching and scratching (due to histamine release). Symptoms of opioid withdrawal include yawning, anxiety, muscle aches, abdominal cramps, headache, dilated pupils, difficulty sleeping, vomiting, diarrhea, piloerection (gooseflesh), agitation, myoclonic jerks, restlessness, delirium, seizures and elevated respiratory rate, blood pressure and pulse.

Drug Use Questionnaire (DAST-20)

These questions refer to the past 12 months.

1.	Have you ever used drugs other than required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had “blackouts” or “flashbacks” as a result of drug use?.....	Yes	No
7.	Do you feel bad or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your drug use?	Yes	No
11.	Have you neglected your family because of your drug use?	Yes	No
12.	Have you been in trouble at work because of drug use?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?.....	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you experienced withdrawal symptoms (felt sick) when you stop taking drugs? ..	Yes	No
18.	Have you had medical problems as a result of your drug use? (e.g., memory loss, hepatitis, convulsions, bleeding, etc.).....	Yes	No
19.	Have you gone to anyone for help for a drug problem?	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No

Detoxification from Alcohol and Drugs

The Substance Abuse and Mental Health Services Administration (SAMHSA) Consensus Panel supports the following statement and has taken special care to note that detoxification is not substance abuse treatment and rehabilitation:

- “Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient was left untreated. At the same time, detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalization or legal involvement. Finally, for some patients it represents a point of first contact with the treatment system and the first step to recovery. Treatment/rehabilitation, on the other hand, involves a constellation of ongoing therapeutic services ultimately intended to promote recovery for substance abuse patients.”

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LONG-TERM CARE

MHC will ensure that eligible members, other than members requesting hospice, in need of nursing facility services are placed in facilities providing the appropriate level of care commensurate with the member's medical needs.

Eligibility and Referral

When a referral to a long-term care facility is initiated by an in-patient attending physician, the MHC Medical Director will be notified by the hospital Utilization Review Coordinator or MHC Utilization Management Department. The hospital Discharge Planner will notify the MHC PCP of such referral.

Referral to the appropriate long-term care facility should be made when the Provider/Practitioner has determined that the member meets, or may meet, the criteria for any of the following long-term care facilities:

- Transitional care
- Intermediate care facility
- Sub-acute care facility
- Rehabilitative care facility
- Pediatrics sub-acute care facility
- Skilled nursing facility (SNF)
- Short-term care
- Long-term care
- Custodial care

Potentially appropriate members for long-term care referral are identified by MHC's or affiliated health plan's Utilization Management Nurse Reviewers during the admission and concurrent review process.

Other sources of identification include, but are not limited to, case managers, specialty care Providers/Practitioners, social workers, discharge planners, and any other health care Providers/Practitioners involved in the member's care.

Long-term care guidelines for determining the appropriate level of care are based on the MC/FFS guidelines.

Authorization

The PCP will perform an assessment of the member's needs to determine appropriate level of service prior to the request for an admission to a long-term care facility. The PCP will obtain an authorization for admission to a long-term care facility from MHC's Utilization Management Department. The Utilization Management Department will direct the admission to a contracted long-term care facility. If a contracted facility is unavailable to meet the member's needs, the member will be placed at an appropriate facility on a case-by-case basis. All members receiving care in a long-term care facility will be reviewed on a weekly basis with the Utilization Management Medical Director.

If the member does not meet the criteria for an admission to a long-term care facility, the Utilization Management Department will continue to provide case management services until the treatment is completed.

Hospice Care

Hospice services are a covered benefit regardless of the expected or actual length of stay in a nursing home. Members with terminal illnesses (a life expectancy of less than six (6) months) are candidates for hospice services. The determination of medical appropriateness for hospice is performed by the PCP or the Provider/Practitioner in charge of the member's care.

Once the determination for hospice is deemed appropriate, the PCP will obtain an authorization from the CAM Department. The Utilization Management Nurse Reviewer will monitor the case and ensure coordination of all necessary services.

MAJOR ORGAN TRANSPLANTS

Organ transplants are a covered benefit of the Medi-Cal program. Under the GMC, MHC is responsible for identifying and referring patients to Medi-Cal approved facilities for evaluation. Members undergoing transplants are to be disenrolled except for kidney or cornea transplants for which MHC retains full responsibility.

The Medi-Cal program has established specific patient and facility selection criteria for each of the following Medi-Cal major organ transplants:

- Bone marrow transplants
- Heart transplants
- Liver transplants
- Lung transplants
- Heart/lung transplants
- Combined liver and kidney transplants
- Combined liver and small bowel transplants
- Small bowel transplants

Eligibility

Final authorization of major organ transplants is the responsibility of the Medi-Cal Field Office and, for children under 21 years of age, the California Children's Services (CCS) Central Office.

The PCP is responsible for identifying members who are potential candidates for a major organ transplant, for initiating a referral to appropriate specialists and/or transplant centers, and for coordinating care. The PCP may contact the Medical Director or Care Access and Monitoring department of MHC to assist in the referral process.

Referrals

- The PCP will identify members who may be potential candidates for major organ transplant. Following the identification, the PCP will initiate a referral to a specialist and/or Medi-Cal approved transplant center and will continue to provide and coordinate care until the member is disenrolled from the Plan
- If the transplant center deems the member to be a potential candidate, the transplant Provider/Practitioner will submit a request for authorization to the Medi-Cal Field Office or CCS Central Office

- Upon receipt of approval or denial of the transplant authorization request, the transplant center will immediately inform the plan so appropriate action may be taken
- If the request is denied because the member's medical condition does not meet DHCS criteria, the Plan remains responsible for the provision of all medically necessary services to the member
- If the request is approved, the health plan Health Care Services Staff will initiate disenrollment of the member in accordance with MHC Policy and Procedure MS-02, Mandatory Disenrollments (including excluded services). To ensure continuity of care to the member, the member will be disenrolled only after the following steps have occurred:
 - The health plan CAM staff has approved a referral of the member to a Medi-Cal designated transplant center for evaluation
 - The transplant center Provider/Practitioner(s) has performed a pre-transplant evaluation on the Plan member and the center's Patient Selection Committee has determined the member to be a suitable candidate for transplant
 - The transplant center Provider/Practitioner(s) has submitted a prior authorization request to the appropriate state office and the transplant procedure has been approved and documentation sent to the health plan Case Management Staff by the transplant center
- The disenrollment request, accompanied by the approved authorization request, has been submitted by MHC to the Health Care Options (HCO) contractor, which will then notify MHC of receipt of the request and initiate the disenrollment process
- In the event of the necessity for an emergency organ transplant, MHC's CAM Staff will assure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization request is submitted to the appropriate State office. When an approval for the transplant, which may be retroactive, is received, the disenrollment request, accompanied by the approved authorization request, will be submitted by the health plan CAM Staff to the HCO contractor, which will notify the health plan CAM Staff of receipt of the request and initiate the disenrollment process
- The effective date of disenrollment will be retroactive to the beginning of the month in which authorization is given. MHC will retain responsibility for providing all medically necessary covered services during the month in which the transplant is authorized, and will request the HCO contractor to initiate a routine, non-retroactive disenrollment
- MHC is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollment. Services performed after the effective date of disenrollment should be billed on a FFS basis
- When the transplant has been approved and the disenrollment process has been initiated, MHC will notify the member and coordinate the transfer of the member's care to the transplant Provider/Practitioner
- PCPs are responsible for continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner
- For members under 21 years of age, the health plan CCS Staff will notify the local CCS program when the disenrollment process has been initiated, in order to maintain continuity of care
- Coordination of care is managed by the PCP, who is assisted by a health plan Case Manager until the member is disenrolled from MHC

The PCP has primary responsibility for the coordination of care:

- Identification of potential Major Organ Transplants candidates
- Provision of primary medical care
- Referral to appropriate specialty care Provider/Practitioner
- Review of all medical records and reports received from transplant center
- Providing education to member regarding his/her condition
- Reinforcing the transplant team's treatment plan
- Referring member to additional psychosocial support resources as needed
- Provide all required documentation to the transplant center

The health plan CAM staff is responsible for the following:

- Referral to a contracted major organ transplant center and ensuring the appointment is scheduled appropriately
- Ensuring transfer of pertinent medical records to transplant center
- Communicating written or verbally as necessary
- Ensuring the transplant center evaluation appointment is kept by the member
- Contacting Member Services to process a member disenrollment from MHC once transplant treatment has been authorized by the Medi-Cal Field Office (if transplants are carved out of MHC's benefit coverage by contract) or the CCS Central Office
- Tracking each phase of the referral process to the transplant center(s)
- The health plan's Medical Director, CAM staff, Case Manager, and member's PCP (and Specialist if applicable) will continue to manage and coordinate member's health care needs with a contracted transplant center, if MHC's benefit coverage includes transplants by contract
- The effective date of the disenrollment is retroactive to the beginning of the month in which the transplant was approved
- If the request for a transplant is denied by the Medi-Cal Field Office or CCS, the health plan's PCP will continue to provide and coordinate the member's care
- The health plan Case Manager will continue to provide case management services until such time that the denial decision is reversed by DHCS upon appeal by the member or the member is no longer eligible.

Disenrollment

If the request is approved, MHC CAM staff will initiate disenrollment of the member. To ensure no disruption of care to the member, the member will be disenrolled only after the following:

- MHC CAM Staff has approved a referral of the member to a Medi-Cal designated transplant center for evaluation.

Major Organ Transplant

- The transplant center Provider/Practitioner has performed a pre-transplant evaluation on the member and the center's Patient Selection Committee has determined the member to be a suitable candidate for transplant.
- The transplant center Provider/Practitioner has submitted a prior authorization request and the transplant procedure has been approved.

- The disenrollment request, accompanied by the approved authorization request, has been submitted by MHC to the Health Care Options (HCO) contractor, which will then notify Molina Healthcare of receipt of the request and initiate the disenrollment process.
- Should an emergency organ transplant be necessary, MHC CAM Staff will ensure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization request is submitted to the appropriate state office.

The effective date of disenrollment will be retroactive to the beginning of the month in which the authorization was given. MHC will retain responsibility for providing a member's medically necessary covered service during the month in which the transplant authorization is given. MHC is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollment. Services performed after the effective date of disenrollment should be billed on a FFS basis.

PCP's Responsibility

PCPs are responsible for ensuring continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner in a timely manner.

It is the responsibility of the PCP to refer any member who is a potential transplant candidate to the CAM Department. Please contact the appropriate Case Management Department as follows:

Molina Healthcare Phone: (800) 526-8196 ext. 127604
Fax: (888) 273-1735

Renal Transplants

Renal transplants for members 21 years and over are a covered benefit. The PCP and Case Management Staff will refer the identified member to a DHCS licensed and certified hospital with a renal transplant unit. The PCP is responsible for the coordination of all necessary primary care services and for the provision of all services related to renal transplantation, including the evaluation of potential donors and nephrectomy from living or cadaver donors.

Members under age 21 years in need of evaluation as potential renal transplant candidates will be referred to the appropriate CCS program office for a referral to an approved CCS renal dialysis and transplant center. Requests for renal transplants from CCS approved renal dialysis and treatment centers will be sent to the local CCS Program Office for authorization. The PCP and health plan's CCS Staff will coordinate the referral to the CCS Program Office.

MHC remains responsible for the provision of primary care services and for coordination of care with CCS regarding renal transplant services.

7.6 HEALTHCARE SERVICES: MENTAL HEALTH/SHORT-DOYLE COORDINATION & SERVICES

Effective January 1, 2014, as established in W&I Code Sections (§§) 14132.03 and 14189, Medi-Cal managed care plans, including MHC and contracted network providers, are required to cover certain outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems).

As of January 1, 2014, MHC is offering the following expanded mental health services to Medi-Cal managed care members meeting medical necessity or Early Periodic Screening Diagnosis and Treatment (EPSDT) and/or members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems):

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient services that include laboratory work, medications (excluding anti-psychotic drugs which are covered by Medi-Cal FFS), supplies and supplements
- Psychiatric consultation
- Screening and brief intervention

The following specialty mental health services are excluded from MHC's coverage responsibility, but will continue to be provided by the County mental health agencies for members who meet medical necessity criteria or EPSDT and/or members with severe impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis. MHC contracted providers should direct members who are receiving or eligible for such services to County mental health/behavioral health services.

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

- Psychiatric inpatient hospital professional services
- Psychiatric health facility services

The following services are excluded from MHC’s coverage responsibility, but are provided by County Alcohol and Other Drug (AOD) programs:

- Outpatient services
 - Outpatient drug-free program
 - Intensive outpatient (newly expanded to additional populations)
 - Residential services (newly expanded to additional populations)
 - Narcotic treatment program
 - Naltrexone

- New Services
 - Voluntary inpatient detoxification

Primary care providers continue to be responsible for screening and brief intervention, and in performing all preliminary evaluations necessary to develop a diagnosis prior to referring member to applicable county agency or program. Screening tools are available on the DHCS and our provider website at molinahealthcare.com. Screening tools include the Staying Healthy Assessment/Individual Health Education Behavioral Assessment (IHEBA). Please refer to the released guidelines regarding the use of the IHEBA in Policy Letter (PL) 13-001 (Revised) and the “New Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment.”

Psychiatric Scope of Services for the PCP

These services are limited; examples of services that are generally considered psychiatric primary care services are listed below. However, the PCP must have received appropriate training and provide only those services consistent with state and federal regulations and statutes:

- Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)
- Diagnose physical disorders with behavioral manifestations
- Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-Practitioner therapist
- Diagnose and manage child/elder/dependent-adult abuse and victims of domestic violence

PCP Responsibilities – Primary Caregiver and Referrals

PCPs will provide outpatient mental health services within their scope of practice. Should the member’s mental health needs require specialty mental health services (as indicated above), the PCP should refer the member to the County Mental Health Department for assessment and referral to an appropriate mental health Provider/Practitioner. The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition resulting in a referral.

The PCP will assure appropriate documentation in the member's medical record. The PCP will coordinate non- SD/MC conditions and services with specialists as necessary.

Continuity of Care

PCPs will provide services and referrals in a manner that ensures coordinated and continuous care to all members needing mental health services, including appropriate and timely referral, documentation of referral services, monitoring of members with ongoing medical conditions, documentation of emergency and urgent encounters with appropriate follow-up, coordinated discharge planning, and post-discharge care.

To assure continuity of care when a member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the member's records to that health care Provider/Practitioner and, if appropriate, to the organization where future care will be rendered. Any transfer of member medical records and/or other pertinent information should be done in a manner consistent with confidentiality standards including a release of the medical records signed by the member.

Confidentiality

Confidential member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment.

It is the policy of MHC that all of its employees and contracting Provider/Practitioners respect each member's right of confidentiality and treat the member information in a respectful, professional, and confidential manner consistent with all applicable federal and state requirements. Discussion of member information should be limited to that which is necessary to perform the duties of the job.

Reports from specialty services and consultations are placed in the patient's chart at the PCP's office. Mental health services are considered confidential and sensitive. Any follow-up consultation that the PCP receives from the specialist or therapist is placed in the confidential envelope section of the member's medical record. Please refer to MHC Policy and Procedure MR-26, Collection/Use/Confidentiality, and Release of Primary Health Information and MS-07, Safeguarding and Protecting Medical Records.

Problem Resolution

If a disagreement occurs between MHC and the California Department of Mental Health regarding responsibilities, the Utilization Management Department is notified. All medical records and correspondence should be forwarded to:

Molina Healthcare of California
Attn: Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
Telephone: (800) 526-8196
Fax: (888) 273-1735

The Utilization Management Department shall:

- Review medical records for issue of discrepancy and discuss with MHC Medical Director
- Discuss with the California Department of Mental Health the discrepancy of authorization responsibility and the MHC clinical review determinations
- MHC will authorize all services that are medically necessary that are not excluded from the contract agreement for Medi-Cal managed care
- If a dispute cannot be resolved to the satisfaction of the California Department of Mental Health or MHC, a request by either party may be submitted to the Department of Health Care Services within fifteen (15) calendar days of the completion of the dispute resolution process outlined in the applicable Memorandum of Understanding (MOU) (the request for resolution shall contain the items identified in Title 9, CCR Section 1850.505)
- MHC will communicate issues and determinations to the PCP and other involved parties.

7.7 HEALTHCARE SERVICES: BREAST & PROSTATE CANCER TREATMENT INFORMATION REQUIREMENTS

SPECIAL REQUIREMENTS FOR INFORMATION AND/OR CONSENT FOR BREAST AND PROSTATE CANCER TREATMENT

Breast Cancer Consent Requirements

A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to patients. A brochure has been prepared to accomplish this task and is available at the following address:

Medical Board of California
Breast Cancer Treatment Options
1426 Howe Street, Suite 54
Sacramento, CA 95825

Order requests can be faxed to (916) 263-2479. There is no charge for the brochure and it is available in bundles of 25, up to a maximum of 2 cases – 250 copies per case. It is available in the following languages: English, Spanish, Korean, Chinese, Russian, and Thai.

The brochure should be given to the patient before a biopsy is taken, whether or not treatment for breast cancer is planned or given. The brochure may not supplant the physician's duty to obtain the patient's informed consent. In addition to the distribution of the brochure, physicians should discuss the material risks, benefits, and possible alternatives of the planned procedure(s) with the patient and document such discussion in the medical record of the patient. Failure to provide the required information constitutes unprofessional conduct.

Every physician who screens or performs biopsies for breast cancer must post a sign with prescribed wording relating to the above brochure. The sign or notice shall read as follows:

“BE INFORMED”

“If you are a patient being treated for any form of breast cancer, or prior to performance of a biopsy for breast cancer, your physician and surgeon is required to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 109275 of the California Health and Safety Code.”

“The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures.”

The sign must be posted close to the area where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8 1/2” X 11” and conspicuously displayed so as to be readable. The words “BE INFORMED” shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese.

Prostate Cancer Screening and Treatment Information to Patients

Providers/Practitioners are required to tell patients receiving a digital rectal exam that a prostate-specific antigen (P.S.A.) test is available for prostate cancer detection.

The National Institute of Health currently provides a prostate cancer brochure entitled: “What You Need to Know about Prostate Cancer.” It is available by calling (800) 4CANCER.

Brochures can also be ordered by going online to www.cancer.gov or faxing an order to (301) 330-7968. The first 20 brochures are free and there is a \$.15/brochure fee for orders over 20, with a minimum order of \$8.00.

Every physician who screens for or treats prostate cancer must post a sign with prescribed wording referencing this information. The sign or notice shall read as follows:

“BE INFORMED”

“If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 109280 of the California Health and Safety Code.”

“The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of advantages, disadvantages, risks, and descriptions of procedures.”

The sign must be posted close to the area where the prostate cancer screening or treatment is performed or at the patient registration area. The sign must be at least 8 1/2” X 11” and conspicuously displayed so as to be readable. The words “BE INFORMED” shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese. The sign shall include the internet web site address of the State Department of Health Care Services and the Medical Board of California and a notice regarding the availability of updated prostate cancer summaries on these web sites.

Information for Patients

The California Department of Public Health (CDPH) has information about breast and prostate cancer on their website

at: <http://www.cdph.ca.gov/HealthInfo/Pages/BreastCancerInformation.aspx>

Information can be viewed or printed from this website.

7.8 HEALTHCARE SERVICES: HUMAN REPRODUCTIVE STERILIZATION PROCEDURE & CONSENT

Members must be appropriately and adequately informed about human reproductive sterilization procedures. Informed consent must be obtained prior to performing a procedure that renders a person incapable of producing children. Sterilization performed because pregnancy would be life threatening to the mother is included in this requirement. When sterilization is the unavoidable secondary result of a medical procedure and the procedure is not being done in order to achieve that secondary result, the procedure is not included in this policy.

Conditions for Sterilization

Sterilization may be performed only under the following conditions:

- The member is at least 21 years old at the time the consent is obtained.
- The member is not mentally incompetent, as defined by Title 22, i.e., an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared incompetent for purposes which include the ability to consent to sterilization.
- The member is able to understand the content and nature of the informed consent process.
- The member is not institutionalized, as defined by Title 22, i.e., someone who is involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- The member has voluntarily given informed consent in accordance with all of the prescribed requirements.
- At least thirty (30) days, but not more than one hundred eighty (180) days, have passed between the date of written informed consent and the date of the sterilization. Exceptions are addressed below.

Conditions When Informed Consent May Not Be Obtained

Informed consent may not be obtained while the member to be sterilized is:

- In labor or within twenty four (24) hours postpartum or post-abortion.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or other substances that affect the member's state of awareness.

Informed Consent Process Requirements

The following criteria, including the verbal and written member information requirements, must be met for compliance with the informed consent process:

- The informed consent process may be conducted either by Provider/Practitioner or appropriate designee.
- Suitable arrangements must be made to ensure that the information specified above is effectively communicated to any individual who is deaf, blind, or otherwise handicapped.

- An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent.
- The member to be sterilized must be permitted to have a witness present of that member's choice when consent is obtained.
- The sterilization procedure must be requested without fraud, duress, or undue influence.

Required Member Information

The member requesting to be sterilized must be provided with the appropriate booklet on sterilization published by the Department of Health Care Services (DHCS) **BEFORE THE CONSENT IS OBTAINED**. These are the only information booklets approved by DHCS for distribution to individuals who are considering sterilization:

- "Understanding Sterilization for a Woman"
- "Entendiendo La Esterilizacion Para La Mujer"
- "Understanding Vasectomy"
- "Entendiendo La Vasectomia"

Providers/Practitioners may obtain copies of the information booklets provided to members in English or Spanish by submitting a request on letterhead to:

California Department of Health Care Services
 Warehouse - Forms Processing
 1037 North Market Blvd., Suite 9
 Sacramento, CA 95834
 Fax: (916) 928-1326

When the Providers/Practitioners or appropriate designee obtains consent for the sterilization procedure, he/she must offer to answer any questions the member to be sterilized may have concerning the procedure. In addition, all of the following must be provided verbally to the member who is seeking sterilization:

- Advice that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits he/she is entitled to.
- A full description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of discomforts and risks that may accompany or follow the procedure, including explanation of the type and possible side effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected from sterilization.
- Approximate length of hospital stay and approximate length of time for recovery.
- Financial cost to the member. Information that the procedure is established or new.
- Advice that sterilization will not be performed for at least thirty (30) days, except in the case of emergency abdominal surgery or premature birth (when specific criteria are met).
- The name of the Provider/Practitioner performing the procedure. If another Provider/Practitioner is to be substituted, the member will be notified, prior to administering pre-anesthetic medication, of the Provider/Practitioner's name and the reason for the change in Provider/Practitioner.

The required consent form PM 330 must be fully and correctly completed after the above conversation has occurred. Consent form PM 330, provided by DHCS in English and Spanish, is the ONLY form approved by DHCS.

The PM 330 must be signed and dated by:

- The member to be sterilized.
- The interpreter, if utilized in the consent process.
- The person who obtained the consent.
- The Provider/Practitioner performing the sterilization procedure.

By signing consent form PM 330, the person securing the consent certifies that he/she has personally:

- Advised the member to be sterilized, before that member has signed the consent form, that no federal benefits may be withdrawn because of a decision not to be sterilized.
- Explained verbally the requirements for informed consent to the member to be sterilized as set forth on the consent form PM 330.
- Determined to the best of his/her knowledge and belief, that the member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The Provider/Practitioner performing the sterilization certifies, by signing the consent form PM 330, that:

- The Provider/Practitioner, within seventy two (72) hours prior to the time the member receives any preoperative medication, advised the member to be sterilized that federal benefits would not be withheld or withdrawn because of a decision not to be sterilized.
- The Provider/Practitioner explained verbally the requirements for informed consent as set forth on the consent form PM 330.
- To the best of the Provider/Practitioner's knowledge and belief, the member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.
- At least thirty (30) days have passed between the date of the member's signature on the consent form PM 330 and the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is met.

The interpreter, if one is utilized in the consent process, will sign the consent form PM 330 to certify that:

- The interpreter transmitted the information and advice presented verbally to the member.
- The interpreter read the consent form PM 330 and explained its content to the member.
- The interpreter determined, to the best of the interpreter's knowledge and belief, that the member to be sterilized understood the translated information/instructions.

Medical Record Documentation

There must be documentation in the progress notes of the member's medical record that a discussion regarding sterilization has taken place, including the answers given to specific questions or concerns expressed by the member. It will be documented that the booklet and copy

of the consent form were given to the member. The original signed consent form must be filed in the member's medical record. A copy of the signed consent form must be given to the member and a copy is placed in the member's hospital medical record at the facility where the procedure is performed.

If the procedure is a hysterectomy, a copy of the informed consent form for hysterectomy should be placed in the member's medical record. This form is supplied by the facility performing the procedure.

Office Documentation

All participating Providers/Practitioners are responsible for maintaining a log of all human reproductive sterilization procedures performed. A sample of sterilization log is provided for your reference. This log must indicate the member's name, date of sterilization procedure, the member's medical record number, and the type of procedure performed.

Exceptions to Time Limitations

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the following requirements are met:

- A minimum of seventy two (72) hours have passed after written informed consent to be sterilized, and
- A written informed consent for sterilization was given at least thirty (30) days before the member originally intended to be sterilized, or
- A written informed consent was given at least thirty (30) days before the expected date of delivery

Special Considerations, Hysterectomy

A hysterectomy will not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a hysterectomy consent form must be completed in addition to other required forms.

Noncompliance

The Quality Improvement Department monitors compliance for the consent process of human reproductive sterilization. Identified deficiencies will be remedied through a course of corrective action(s) as determined appropriate by the Quality Improvement Committee with following reviews conducted to assess improvement or continued. The DHCS also performs audits for compliance with Title 22. Both MHC and DHCS are required to report non-complaint Providers/Practitioners to the Medical Board of California.

Ordering of Consent Forms

Sterilization consent forms PM 330, with English printed on one (1) side and Spanish on the other side, can be ordered directly from DHCS by sending a request to:

Medi-Cal Benefits Branch
California Department of Health Care Services
714 P Street, Room 1640
Sacramento, CA 95814

8.0 PHARMACY/FORMULARY

DRUG FORMULARY

Molina Healthcare of California (MHC) maintains its own Drug Formulary. MHC's Pharmacy and Therapeutics Committee meets quarterly to review and recommend medications for formulary consideration. As each edition of the formulary is printed, it is then distributed to MHC Providers / Practitioners who have requested a hard copy of the formulary booklet. Provider/Practitioner may request additional copies by calling the MHC Provider Services Department. The current Drug Formulary and updates are available on the MHC website. An interactive version of the Formulary is also available for PDA download at www.epocrates.com.

Over-the-Counter (OTC) Drugs

MHC covers a wide selection of over-the-counter (OTC) products. Although specific products may at times differ from the State's Medi-Cal Formulary, all appropriate therapeutic categories are represented with a wide selection of alternatives.

Generic Substitution

Generic drugs should be dispensed whenever available. If the use of a particular brand name becomes medically necessary as determined by the Provider/Practitioner, prior authorization must be obtained from MHC.

Non-Formulary Drug Prior Authorization

Non-formulary drugs may be obtained via the Drug Prior Authorization process.

Drug Prior Authorizations

Prescriptions for medications requiring prior approval or for medications not included on the MHC Drug Formulary may be obtained when medically necessary and when formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, the Provider/Practitioner may fax a completed "Medication Prior Authorization Request" form to MHC at (866) 508-6445. The requesting Providers/Practitioners may expect a response within one (1) business day. A blank Medication Prior Authorization Request form may be obtained by accessing the MHC website or by calling (800) 526-8196.

PolyPharmacy Program

MHC has a six (6) prescription limit per month. Members with a diagnosis of HIV/AIDs, transplant, or cancer are exempted from this program. In addition, MHC has a Preferred Drug list of medications that do not count towards a members prescription limit. Drugs on the Preferred Drug List should be prescribed at a 60 day supply. Provider/Practitioner with members who require an exemption from the 6 prescription per month limit may request an exemption from the PolyPharmacy program by filling out the Polypharmacy exemption form on the MHC website. If a member has met their prescription limit for the month, the Provider/Practitioner may obtain an override by faxing a completed "Medication Prior Authorization Request" form to MHC.

Pharmacy Home - A Pharmacy Lock-In Program

The Pharmacy Home program is MHC's Pharmacy Lock-In Program. This program is offered to members residing in San Diego, Sacramento, and Inland Empire counties. This program monitors members who have filled claims for a controlled substance prescription at three (3) or more different pharmacies in a one (1) month period, twice in a calendar year and locks the members into one (1) pharmacy to obtain all of their controlled substance medications for a twelve month period. In situations where the members' Pharmacy Home is closed or unable to supply the needed medication(s), the members may receive a sufficient quantity (up to a 72 hour supply) of their controlled substances from a pharmacy outside of their Pharmacy Home.

Prior to the end of the members' lock-in period, MHC will assess the need for continued enrollment in the Pharmacy Home Program.

MHC will inform you if any of your patients are enrolled in the Pharmacy Home program. If you would like a copy of your patients' controlled substance report filled through MHC, please contact the Pharmacy Department at (800) 526-8196.

Furnishing of Medication by Physician Assistants and Nurse Practitioners

Furnishing (including transmittal orders) of medication by Physician Assistants (PAs) and Nurse Practitioners (NPs) should be done pursuant to Chapters 3502.1 and 2836.1 of the California Business and Professions Code. PAs hold a valid California Physician Assistant license issued by the Physician Assistant Examining Committee and their supervising physicians hold a valid California Physician License to supervise PAs. NPs must have obtained a furnishing number from the Board of Registered Nursing. Midlevel Practitioners should prescribe medication within the scope of standardized procedures developed and approved by a supervising physician, surgeon, facility administrator, or designee.

MANAGEMENT AND DOCUMENTATION OF CONTROLLED SUBSTANCES

Storage of Controlled Substances

All controlled substances should be stored in a double locked cabinet. Only licensed personnel may assume responsibility for handling or carrying keys to the controlled medication cabinet. All missing or lost keys should be reported to the Provider/Practitioner in charge immediately.

Inventory of Controlled Substances

There should be a current inventory maintained on each controlled substance. A printed log should be produced which lists only those controlled substances stocked by the office/clinic. Controlled substances added to the inventory should be recorded in the log and verified by two (2) licensed personnel.

Security of Controlled Substances

Obvious signs of tampering with controlled substances and/or the locked cabinet should be reported to the Drug Enforcement Agency (DEA) if significant or chronic loss occurs. DEA notification is not needed for a rare loss of a small quantity or if a small discrepancy in the

inventory log is noted. However, documentation must be maintained regarding any discrepancies.

Controlled Substance Administration Documentation

Documentation should be maintained regarding the administration of all controlled substances.

Controlled Substance Discrepancy

If at any time a discrepancy in the controlled substances inventory is found, it should be reported to the Provider/Practitioner in charge. The Provider/Practitioner in charge should report the discrepancy to the DEA if a significant loss or chronic loss of controlled substances occurs. The discrepancy should be documented and kept on file with the inventory log. All licensed personnel who have had access to the controlled medication cabinet keys should remain on duty until the Provider/Practitioner in charge has finished investigating the discrepancy.

Disposal of Controlled Substances

All wasted, contaminated, deteriorated, or expired controlled substances should be destroyed in the presence of two (2) licensed personnel (i.e. Provider/Practitioner in Charge, Registered Nurse (RN), or Licensed Vocational Nurse (LVN)). The following information should be documented:

- Medication name and strength
- Amount destroyed
- Lot number and expiration date
- Signatures of both licensed personnel
- Patient for whom medication was intended, if applicable

GENERAL MEDICINE POLICY

Medication Storage

All medications, needles, syringes, and dangerous medical supplies should be stored in an area accessible only to authorized personnel.

Medications must be stored separately, according to their route of administration. Germicides, disinfectants, test/reagents, household cleaning supplies, and other products for external use must be stored separately. All medications should be stored in their original containers.

Medications must be stored at temperature levels specified by the manufacturer. MHC policies require that a system is in place to ensure that temperature levels are maintained.

Expiration Dates

All medications and related items should be routinely checked for expiration. Drugs should not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs should be used. All unopened expired medications should be returned to the manufacturer if possible or discarded in a manner safe to the environment. Documentation of the destruction of all scheduled medications should be in accordance with DEA policies.

For injectable products designed for multiple uses, the expiration date should be the manufacturer's printed expiration date if upon inspection the product does not show signs of contamination, such as discoloration or particulate matter. All single dose containers should be discarded immediately after use.

For diagnostic products or test strips which are acceptable for multiple uses, the manufacturer's printed expiration date should be considered the expiration date.

Labeling Requirements

All medications should be properly labeled with the name and strength of medication, the manufacturer's name and lot number (#), and expiration date.

All medications that are transferred from their original container into another (repackaged) or those that are extemporaneously prepared (compounded) should be labeled with the following information:

- Name, strength, and quantity of medication
- Expiration date (of original container if repackaged or of ingredients if compounded)
- Manufacturer's name and original lot number (#)
- Date of repackaging (or compounding) and initials of repackager

Pharmaceutical Samples

Molina Medical Groups do not keep pharmaceutical samples. Provider/Practitioner offices that do should keep the following in mind:

- The Provider/Practitioner is ultimately responsible for the storage, inventory, and dispensing of all samples
- Samples should be dispensed only by the Provider/Practitioner. This responsibility should not be delegated to other office staff
- Samples should be dispensed only to the Provider/Practitioner's own patient and should not be sold
- Samples should be stored in the secured manner described previously
- If samples are dispensed, they must meet all labeling requirements as described previously
- A sample log should be maintained and used whenever samples are received or dispensed
- An appropriate notation should be entered in the patient's record, in a similar manner as if a prescription had been written.

EXCLUDED DRUGS: BILL MEDI-CAL FEE-FOR-SERVICE DIRECTLY

The Department of Health Care Services through the Medi-Cal Fee-For-Service (FFS) program has assumed financial responsibility of select antipsychotics, detoxification/dependency treatments, and HIV/AIDS medications. The following drugs should be billed to Fee-For-Service Medi-Cal, using standard Electronic Data Systems (EDS) prior authorization and billing procedures. **MHC pharmacies will not be able to bill MHC directly for any of these drugs. Should they attempt to do so, the pharmacy computer systems have been programmed to reject the claim and display the message “Bill Medi-Cal Fee-For-Service.”** Pharmacies should already be aware of this procedure. Should they have any further questions, they can always call the MHC Pharmacy Desk at (800) 526-8196.

PSYCHIATRIC DRUGS (LISTED BY GENERIC NAME)		
Acamprosate Calcium	Haloperidol Decanoate	Procyclidine HCL
Amantadine HCL	Haloperidol Lactate	Promazine HCL
Aripiprazole	Isocarboxazid	Quetiapine
Benzotropine Mesylate	Lithium Carbonate	Risperidone
Biperiden HCL	Lithium Citrate	Selegiline
Biperiden Lactate	Loxapine HCL	Thioridazine HCL
Buprenorphine HCl	Loxapine Succinate	Thiothixene
Buprenorphine/Naloxone HCl	Mesoridazine Mesylate	Thiothixene HCL
Chlorpromazine HCL	Molindone HCL	Tranlycypromine Sulfate
Chlorprothixene	Naltrexone (oral and injectable)	Trifluoperazine HCL
Clozapine	Olanzapine/Olanzapinefluoxetine	Triflupromazine HCL
Fluphenazine Decanoate	Paliperidone	Trihexyphenidyl HCL
Fluphenazine Enanthate	Perphenazine	Ziprasidone
Fluphenazine HCL	Phenelzine Sulfate	
Haloperidol	Pimozide	

HIV DRUGS (LISTED BY GENERIC NAME)		
Abacavir/Lamivudine	Enfuvirtide (Fuzion)	Raltegravir Potassium
Abacavir Sulfate (Ziagen)	Etravirine	Ritonavir (Norvir)
Amprenavir (Agenerase)	Fosamprenavir Calcium (Lexiva)	Saquinavir (Invirase, Fortovase)
Atazanavir (Reyataz)	Indinavir Sulfate (Crixivan)	Stavudine (Zerit)
Darunavir Ethanolate	Lamivudine (Epivir)	Tenofovir Disoproxil Fumarate (Viread)
Delavirdine Mesylate (Rescriptor)	Lopinavir/Ritonavir (Kaletra)	Tenofovir Disoproxil-Emtricitabine
Efavirenz (Sustiva)	Maraviroc	Tenofovir Disoproxil
Efavirenz/Emtricitabine/Tenofovir	Nelfinavir Mesylate (Viracept)	Zidovudine/Lamivudine
Emtricitabine (Emtriva)	Nevirapine (Viramune)	Zidovudine/Lamivudine/Abacavir Sulfate

DETOXIFICATION/DEPENDENCY TREATMENTS (LISTED BY GENERIC NAME)	
Acamprosate Calcium	Buprenorphine HCl
Buprenorphine/Naloxone HCl	Naltrexone (oral and injectable)

9:0 CLAIMS & ENCOUNTER DATA

CLAIMS

As a contracted Provider/Practitioner, it is important to understand how the claims process works to expedite the processing of your claims. The following items are covered in this section for your reference and convenience:

- Claim Filing Timeframe
- Complete Claim Definition
- Claim Review
- Claims Acknowledgement
- Claims Submission Instructions
- Claims Submission
- Claims Documentation
- Misdirected Claims
- Claims Receipt Verification
- Electronic Claims Transactions
- Provider Disputes
- Submission of Provider Inquiry Request
- Overpayment of Claims
- Claim Processing Timeframes
- Coordination of Benefits
- Third-Party Tort Liability
- Claim Auditing Fee-For-Service Providers
- Shared Risk Claims

Claim Filing Timeframe

Molina Healthcare of California (MHC) will accept complete claims from Providers/Practitioners for processing if received within one hundred and eighty (180) days following the date of service. Provider shall promptly submit to MHC, claims for covered services rendered to MHC members. All claims shall be submitted in a form acceptable to and approved by MHC, and shall be complete including any applicable medical records pertaining to the claim as required by MHC's policies and procedures.

Any claims that are not submitted by the Provider/Practitioner to MHC within one hundred eighty (180) days of providing the covered services that are the subject of the claim shall not be eligible for payment, and Provider/Practitioner hereby waives any right to payment therefore.

Complete Claim Definition

MHC will adjudicate complete claims, which is a claim or a portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. In select circumstances, MHC may require additional information from a Provider/Practitioner for errors such as where the Plan has reasonable grounds for suspecting possible fraud, misrepresentations, or unfair billing practices.

Claim Review

A claim will be subject for appropriate billing review to determine if services are billed in accordance to the American Medical Association guidelines and review of unbundling services. MHC reviews provider claims for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, CMS approved diagnostic and procedural coding, CMS billing rules, CMS bundling / unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and

determinations of designated implantable devices and/or implantable orthopedic devices. MHC conducts such review and audit on a line-by-line basis or on such other basis as MHC deems appropriate billing.

Claims Submitted via Paper

MHC will acknowledge receipt of paper claims, whether or not complete, within fifteen (15) working days of receipt. You may confirm receipt of your paper claims via telephone or via our Provider Self-Services E-Portal. We encourage you to use our Web Portal as you may routinely access claims status twenty four (24) hours a day, seven (7) days a week.

- To check via telephone, please call our Claims Call Center staff at (888) 665-4621 between the hours of 8:00 a.m.-5:00 p.m., Monday through Friday.
- To check the status of your claims via the MHC website, please visit our Provider Self-Services Web Portal system at www.MolinaHealthcare.com.

Claims Submitted Electronically

For electronically submitted claims, MHC will similarly acknowledge receipt electronically within two (2) working days.

- If you submit your claims electronically via a clearinghouse, you will receive a 997 acknowledgement and a 277FE within two (2) working days.
- Practitioners registered on our Provider Self Services E-Portal can submit professional claims online. After you successfully submit a professional claim via the Provider Self-Services Web-Portal, the next screen will display a message notifying you that your claim was successfully submitted, along with the claim number.

MHC will adjudicate each complete claim or portion thereof according to the agreed upon contract rate, no later than forty five (45) working days after receipt unless the claim is contested or denied. If a claim is contested or denied, the provider will receive a written determination stating the reasons for this status no later than forty five (45) working days after receipt.

Claims Submission Instructions (Production Environment)

Claims should be submitted to the PO Box listed below:

Molina Healthcare of California
P.O. Box 22702
Long Beach, CA 90801

Claims Submission

MHC will adjudicate complete claims, which is a claim or portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. MHC may require additional information from a Provider/Practitioner where the plan has reasonable grounds for suspecting fraud, misrepresentations, or unfair billing practices.

Claims will be submitted to MHC or affiliated IPA/Medical Group with the appropriate documentation. The requirements for documentation are designed to streamline the claims payment process. Submission of complete, timely claims allows the payer to process the claims with a minimum of manual handling.

The following information must be included on every claim:

- Provider/Practitioner name, address, and Federal Tax ID number
- Member name, date of birth and Medi-Cal Benefits Identification Card (BIC) number
- Date(s) of service
- CMS approved diagnostic and procedural coding
- Billed charges for service provided
- Place of service or UB-04 bill type code
- Submitting provider tax identification and/or social security number
- Name and state license number of attending provider

Documents that do not meet criteria described above will be returned to the Provider/Practitioner indicating necessary information missing. In addition, claims must be submitted on the proper claim form, i.e., a UB-04, CMS-1500, or Universal Drug Claim Form. These forms are available from office supply stores and medical form vendors. MHC and affiliated IPAs will only process legible claims received on the proper claim form that contains essential data requirements.

Claims Documentation

To ensure timely claims processing, MHC requires that adequate and appropriate documentation be submitted with each claim filed.

DOCUMENTATION REQUIRED WITH A CMS-1500 CLAIM FORM	
PROVIDER TYPE	DOCUMENTATION
All Providers/Practitioners	- Medicare/other coverage Explanation of Benefits
Dialysis Service	- Dialysis log
Home Health	- Doctor’s orders & nurses notes
Physician (specialist)	- Consult report - Flow Sheet for OB Care - Copy of referral form
Physician (emergency medicine)	- Emergency room report
Surgeon	- Operative report & emergency room report - Sterilization consent form (when applicable) - Authorization number - Discharge summary - History and physical - Medicare/other coverage Explanation of Benefits - Referral form

Providers/Practitioners who are billing MHC must follow these guidelines.

Providers/Practitioners who are contracted through an affiliated IPA/Medical Group must follow the requirements outlined by the IPA/Medical Group when billing for services that are the responsibility of the IPA/Medical Group.

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

The following information must be included on every inpatient UB-04 claim:

- **Institutional Providers:**
 - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statute and regulations and any state designated data requirements included in statutes or regulation.

- **Physicians and Other Professional Providers:**
 - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries stated as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

If a claim is sent directly to MHC, rather than the IPA/Medical Group, and the claim includes both Plan-risk services and capitated-risk services, the Plan will process the appropriate Plan-risk services. Services which are the responsibility of the IPA/Medical Group will be forwarded to the IPA/Medical Group for processing. Claims for capitated services that are misrouted to MHC will be routed back to the appropriate IPA/Medical Group.

Misdirected Claims

In accordance with Title 28, California Code of Regulations (CCR) Section 1300.71, all misdirected claims received by MHC from an IPA/Medical Group/Hospital's sub-contracted provider(s) in error must be forwarded to the proper payer within ten (10) working days of receipt. To comply with this standard, MHC forwards all misdirected claims via hardcopy within ten (10) working days of receipt on a daily basis (as received) to the financially responsible IPA/Medical Group/Hospital for proper adjudication.

To help ensure timely claims adjudication, MHC requests that our contracted IPA/Medical Group/Hospital's delegated for claims payment continuously educate their contracted providers regarding the correct billing address in order to bill the IPA/Medical Group/Hospital directly instead of billing MHC.

Claim Receipt Verification

For verification of claims receipt, contact: MHC Claims Customer Service (888) 665-4621

Electronic Claims Transactions

Below is information to use when submitting MHC Electronic Claims Transactions through the Emdeon (formerly WebMD) Clearinghouse. MHC accepts both professional (CMS-1500) and institutional claims (UB-04) electronically.

MHC's Emdeon Payer ID is: 38333 (MHC pays the claims transaction fee)

Methods to initiate submission of EDI claims:

- You can call (877) 469-3263
- If you are already connected to Emdeon, you can simply use the MHC Emdeon Payer ID
- You can call the HIPAA Hotline at (866) 665-4622

Methods to initiate claims submission status transactions:

- You can call (877) 469-3263
- If you are already connected to Emdeon, you can simply select MHC on menu of Emdeon Empower payers
- You can call the HIPAA Hotline (866) 665-4622

HIPAA required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003. Covered entities include:

- Health plans
- Health care providers who transmit health information in electronic form in connection with a transaction covered by HIPAA
- Health care clearinghouses

Provider Disputes

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested.
- Challenges a request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service on or after January 1, 2004, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the Provider/Practitioner. For paper submission, MHC will acknowledge receipt of the dispute within fifteen (15) working days. If additional information is needed from the Provider/Practitioner, MHC has forty five (45) working days to request necessary additional information. Once notified in writing, the Provider/Practitioner has thirty (30) working days to submit additional information or claim dispute will be closed by MHC.

Providers/Practitioners may initiate a first level appeal by submitting and completing a Provider Dispute Resolution Request Form or a Letter of Explanation within three hundred sixty five (365) days from the last date of action on the issue. The written dispute form must include the Provider/Practitioner name, identification number, contact information, date of service, claim

number, and explanation for the dispute. In addition, the following documentation is required to review and process a claims appeal:

Provider Dispute Resolution Request Form

- A copy of the original claim(s)
- A copy of the disposition of the original claim (s) in the form of the Explanation of Benefit or Remittance Advice
- Documented reason for appeal
- A copy of the medical record/progress notes to support the appeal, when requested

Provider Disputes and supporting documentation (via paper) should be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Dispute Resolution Unit

If you need further information regarding the changes required under Title 28, CCR, Sections 1300.71 and 1300.71.38 related to claims processing and provider disputes please contact MHC at (888) 665-4621.

Resubmission of Claims (Contested)

Please resubmit claims contested with missing information, mailing them to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801

Submission of Provider Inquiry Research and Resolution Claims (MHC Special Projects):

Please submit claim payment/claim denial inquiries to the Provider Inquiry Research and Resolution Department via **Right Fax (562) 499-0603** or via secure email to: MHC_SpecialProjects@MolinaHealthcare.com

Include the following data elements:

- | | |
|-------------------|---------------------------------|
| ▪ Claim number | ▪ Billed amount |
| ▪ Date of Service | ▪ Paid amount (if any) |
| ▪ Member name | ▪ Comments (reason for project) |
| ▪ Member ID | |

Overpayment of Claims

If MHC determines that a claim was overpaid, then MHC will notify the Provider/Practitioner in writing within three hundred sixty five (365) calendar days of the date of payment. Notification of an overpaid claim to the Provider/Practitioner requires the following information: member name and ID number, date of service, and an explanation why MHC believes the claim was overpaid. The Provider/Practitioner has thirty (30) working days to dispute an overpayment notification, which then becomes a provider dispute and follows the applicable procedures listed above under Provider Disputes.

Claims Processing Timeframes

Unless the Subcontracting Provider/Practitioner and Contractor have agreed in writing to an alternate payment schedule, ninety percent (90%) of “clean” claims will be adjudicated within thirty (30) calendar days of receipt. A “clean” claim is one that may be processed without obtaining additional information from the Provider/Practitioner of service or from a third party. However, “clean” claims do not include claims under investigation for fraud or abuse, or claims under review for medical necessity. All claims submitted for which no further written documentation or substantiation is required, are to be processed within forty five (45) working days of receipt.

Coordination of Benefits

MHC and affiliated IPAs/Medical Groups have the liability for payment of authorized claims after all other third parties.

Private insurance carriers, including Medicare, must be billed by the Provider/Practitioner prior to billing MHC, or affiliated IPAs/Medical Groups. The Provider/Practitioner must include a copy of the other insurance’s explanation of benefits (EOB) with the claim.

Cost Avoidance

Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A or N.

Post-Payment Recovery

If Contractor reimburses the provider on a FFS basis, Contractor shall pay the provider’s claim and then seek to recover the cost of the claim by billing the liable third parties for services provided to Members with OHC code.

Third-Party Tort Liability

MHC must identify and notify the Department of Health Care Services within ten (10) days of the discovery of cases in which action by the member involving the tort or Worker’s Compensation liability of a third party could result in recovery by the member of funds to which the Department has lien rights.

MHC or affiliated IPAs/Medical Groups must be notified in writing of all potential and confirmed third party tort liability cases that involve a MHC Medi-Cal Member. Notification must include:

- Member name
- Member identification number and Medi-Cal number
- Date of birth
- Provider name and address
- Date(s) of service
- CMS approved diagnostic and procedural coding
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for denial

Any requests received by subpoena from attorneys, insurers, or members for bill copies must be reported to MHC or affiliated IPAs/Medical Groups. Copies of the request and responses must be forwarded to MHC. Notification and information should be sent to the following addresses:

Molina Healthcare of California
1500 Hughes Way, Pod A 2nd Floor
Long Beach, CA 90810
Attn: Third Party Liability Coordinator

For verification of claims receipt by MHC, contact: Claims Customer Service (888) 665-4621
If the Provider/Practitioner of service is part of an IPA/Medical Group, please contact the IPA/Medical Group for the appropriate mailing address.

When MHC receives a request for information from the Department of Health Care Services (DHCS) on an individual case, a response is required within ten (10) to thirty (30) days of the DHCS request. MHC will be contacting the Provider/Practitioner of service for assistance if needed. The information requested must be returned within ten (10) days.

All claims for services rendered in relation to a third-party tort liability case should be submitted for processing as described in the “Claims Submission” section of this Manual. The claims will follow normal processing guidelines.

Claims Auditing: Fee-For-Service Providers

To verify the accuracy of fee-for-service Provider/Practitioner billings, a MHC representative will conduct random Provider/Practitioner audits.

A sample of claims paid will be pulled and verified against the member’s medical record maintained by the Provider/Practitioner. This audit may occur in the Provider/Practitioner’s office or in the offices of MHC. Where the billing substantially differs from the medical record, the information will be forwarded to the Claims Manager for follow-up and/or screening for fraud and abuse, with subsequent reporting to the DHCS.

Shared Risk Claims

Shared Risk claims should be sent to MHC for adjudication. Additionally, the claims should be separated and batched into Plan or shared risk services and claim types. All claims submitted to MHC must be on CMS-1500, LTC form 25-1, or UB-04 claim forms and indicate the date of receipt by the IPA/Medical Group. Claims for plan or shared risk services must be submitted to:

Molina Healthcare of California
P.O. Box 22702
Long Beach, CA 90801

If a claim is sent directly to MHC, rather than the IPA/Medical Group, and the claim includes both Plan-risk services and capitated-risk services, the Plan will process the appropriate Plan-risk services. Services which are the responsibility of the IPA/Medical Group will be forwarded to the IPA/Medical Group for processing.

Claims for capitated services that are misrouted to MHC will be routed back to the appropriate IPA/Medical Group.

9.1 ENCOUNTER DATA

ENCOUNTER DATA INCENTIVES, CHDP INCENTIVES

Encounter Reporting

The collection of encounter data is vital to Molina Healthcare of California (MHC). Encounter data provides the Plan with information regarding all services provided to our membership.

Encounter data serves several critical needs. It provides:

- Information on the utilization of services
- Information for use in HEDIS studies
- Information that fulfills state reporting requirements

DHCS has implemented standards for the consistent and timely submission of Medi-Cal encounter data. These guidelines will also require heightened accuracy when completing and submitting PM 160 INF forms in order to meet the State of California CHDP Program requirements. MHC is required to submit encounter information to DHCS on a monthly basis.

HIPAA Standards for Electronic Transactions

HIPAA required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003. Covered entities include:

- health plans
- health care providers who transmit health information in electronic form in connection with a transaction covered by HIPAA, &
- health care clearinghouses

The electronic health care transactions covered under HIPAA that may affect provider organizations are:

TRANSACTION DESCRIPTION	HIPAA TRANSACTION STANDARD
Claims or Encounter Information	ASC X12N 837, Professional, or Institutional Health Care Claims (004010X096A198A1)
Eligibility for a Health Plan	ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (004010X092A1)
Referral Certification and Authorization	ASC X12N 278 Health Care Services Review Request for Review and Response (004010X094A1)

Claims Status	ASC X12N 276/277 Health Care Claim Status Request and Response (004010X093A1)
Payment and Remittance Advice	ASC X12N 835 Health Care Claim Payment/Advice (004010X091A1)

HIPAA Provider Hotline Contact Information

For HIPAA TCS questions please call the Toll Free HIPAA Provider Hotline at: (866) 665-4622. You may also obtain information on the MHC website at: www.MolinaHealthcare.com.

Policy

MHC requires all Providers/Practitioners to submit encounter data reflecting the care and services provided to our members.

This policy applies to all Primary Care Practitioners (PCPs), contracted either directly with MHC or through an IPA/Medical Group. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with MHC.

Procedure

Single encounter (for our purposes) is defined as all services performed by a single Provider/Practitioner on a single date of service for an individual member.

The following guidelines are provided to assist our Providers/Practitioners with submission of complete encounter data:

- Reporting of services must be done on a per member, per visit basis
- A reporting of all services rendered by date must be submitted to MHC
- Encounter Data must reflect same data elements required under a 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 Subject to the Following Requirements

- Data must be submitted via our File Exchange Services (FES) site 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 MHC edits will be included in the records evaluated for compliance. Encounters that fail MHC edits will be rejected and error reports will be made available via our File Exchange Services (FES) site or our E-Portal Services at: www.MolinaHealthcare.com. If the failed encounter is corrected and resubmitted within the required timeframe, it will then be included in the calculation for performance standards. Please note that ONLY the corrected encounters are to be resubmitted.

- In no event will incomplete, inaccurate data be accepted.

Tips for Successful Submission

- Encounter data must include the rendering Practitioner/Provider's name and state license number, and the National Provider Identifier (NPI) number whether contracted or non-contracted with an IPA/Medical Group.
- The billing Practitioner/Provider's tax identification number (TIN) and NPI must be included whether contracted or non-contracted with an IPA/Medical Group.
- We encourage multiple/frequent submissions of encounter data on a daily, weekly, or monthly basis to ensure timely submission.

Important Information on Hard Copy Submissions

- Hard copy encounter data for all Medi-Cal and Healthy Families capitated services must be submitted on a CMS 1500 or UB04 form only.
- Hard Copy encounter data must be received by the 5th day of the second month following the date of the encounter (e.g., by September 5th for all encounters occurring in July).

Threshold Requirement

- Threshold: 3.5 encounters per members per month per year
- One hundred percent of CHDP submissions will be applied towards the threshold
- All hard copy encounter data must be submitted to the following address:
Molina Healthcare of California
P.O. Box 22807
Long Beach, CA 90801

Sanctions

Providers/Practitioners will be sanctioned for noncompliance. These sanctions may include ineligibility for the encounter incentive program, freezing new enrollment, capitation withhold, and/or ultimately terminating the capitation contract.

Encounter Data Incentive Requirements

- Encounter Data must reflect all same data elements required under fee-for-service program.
- Encounter data must include the rendering Practitioner/Provider's name and state license number, and the National Provider Identifier (NPI) number.
- Billing Practitioner/Provider's tax identification number (TIN) & NPI must be included.
- CMS approved diagnostic and procedural coding
- Electronic encounter data must be submitted in the HIPAA compliant 837 format only (ASC X12N 837). Electronic encounters not submitted in the HIPAA compliant 837 format will not be eligible to receive the encounter data incentive.
- Hard Copy encounter data must be submitted on a CMS 1500 or UB04 form only.
- All encounter data must be submitted timely and meet the threshold requirements.
- Threshold requirement is 3.5 encounters per member per month, for each line of business.
- Electronic encounter data must be received no later than 90 days from end of month following the date of the encounter (e.g., by October 31st for all encounters occurring in July).

- Hard Copy encounter data must be received by the 5th day of the second month following the date of the encounter (e.g., by September 5th for all encounters occurring in July).
- **Duplicate, rejected and late/untimely submitted encounters will not be allowed towards the threshold requirements nor included in the incentive.**

Note: If you are contracted with an IPA / Medical Group please follow your IPA / Medical Group's Encounter Data Submission guidelines keeping the above standards in mind.

PM 160 INFORMATION ONLY FORM COMPLETION AND SUBMISSION

The California Department of Health Care Services (DHCS) requires that all Medi-Cal Members 0 through their 20th year and 11 months receive periodic health screening exams. Exams performed must meet the requirements of this program utilizing components of the Children's Health and Disability Prevention (CHDP), a part of Children's Medical Services State Program, the American Academy of Pediatricians (AAP) Periodicity Table for Wellness Exams, and the American Academy of Pediatrician Periodicity and Recommendations for Immunizations. All Wellness (CHDP) exams for MHC Medi-Cal members must be documented on the PM 160 Information Only Form (PM 160). The PM 160 form is used for Medi-Cal members enrolled in a managed care plan.

Order Desk

The State of California provides the PM 160 to each managed care plan contracted with Medi-Cal. All forms used to report services for MHC members, **MUST** be ordered directly from MHC. PM 160 Form Order Desk: (800) 5268196, ext. 127371 or 127350, email: MHCEncounterDepartment@MolinaHealthcare.com

CHDP Submissions

All Providers/Practitioners assigned a pediatric population must submit a PM 160 form for all Wellness services rendered to MHC Medi-Cal members 0 through their 20th year and 11 months and according to the screening guidelines on the AAP Periodicity Table.

CHDP Incentive Program

MHC offers a CHDP Incentive Program for certain eligible physicians in participating counties for the timely submission of clean PM 160 Information Only Forms for the provision of CHDP services to Members ages zero (0) through twenty (20). Payment is also subject to compliance with the AAP recommendation for Preventive Pediatric Health Care and Immunizations, Guide to Clinical Preventive Service, a report of the U.S. Preventive Service Task Force.

Eligible physicians must submit a completed MHC Reimbursement Incentive (MRI) Program packet to be considered for the program. The MRI Program packet sets forth the county-by-county eligibility criteria. A completed MRI Program packet includes, but is not limited to, the following documentation:

- Provider Acknowledgement (Completed and signed)
- Provider Assignment of Benefits form (Completed and signed)

- W9 Form
- CHDP Provider and Site Certification (L.A. area only)

For providers approved by MHC for the CHDP Incentive Program, MHC pays an incentive payment for the timely submission of clean PM 160 Information Only Forms for the provision of CHDP services to members ages zero (0) through twenty (20). For eligible capitated providers or providers in a delegated relationship, CHDP services are capitated as Wellness Visits within standard capitation payments, and any CHDP Incentive Program payments received by MHC is in addition to those standard capitation payments for the services.

Required Submission Standards

The following information is required for the processing of PM 160 INF submissions. If these fields are not completed, MHC will contact your office.

- Patient Complete Name
- Patient Date of Birth
- Name of Guardian/Responsible Person
- Date of Service
- Next Visit date
- Ethnic Code
- Vital Signs, Height, Weight and MBI
- Blood Pressure for children 3+ years
- Appropriate services noted for the type of screen given
- Type of screen
- Prepaid project code
- Test Results
- Immunization and test codes

An ICD-9 for every problem diagnosed and follow-up code; if no problems are detected, then the appropriate Wellness exam code **MUST** be used to:

- Completion of the Tobacco Questions
- The patient eligibility section including the County Code, Aid Code, and patient’s identification number
- The rendering provider’s name, service address and Medi-Cal/NPI number
- All PM 160 form submissions **MUST** be signed by the physician rendering service
- If the child is under two (2) months of age, the Mother’s Medi-Cal number may be used

Online submission is preferred and may be done so via E-Portal: www.MolinaHealthcare.com

Where to Send Completed PM 160 Forms

- Copy 1 (white/brown) Send to: Molina Healthcare of California
Attn: CHDP Department
P.O. Box 16027
Mail Stop “HFW”
Long Beach, CA 90806
- Copy 2 (yellow) Send to: Local county CHDP office. PLEASE ensure PCP service site (address, #, county code) are completed - lower left-hand corner of form
- Copy 3 (white) Maintained in the member’s medical record
- Copy 4 (pink) Given to the member (parent/guardian) at the time of the visit



Online PM 160 (Version 8)

Print copy's Give to the member (parent/guardian) at the time of the visit, maintain in the member's medical record, and sign and send to local county CHDP office.

10.0 COMPLIANCE

OVERSIGHT MONITORING

The Medi-Cal Contract between the Department of Health Care Services (DHCS) and Molina Healthcare of California (MHC) defines a number of performance requirements that must be satisfied by both MHC and those Providers/Practitioners and IPA/Medical Groups/Hospitals agreeing, through descending contracting relationships (or subcontracts), to provide services to eligible and enrolled MHC members. Among these are:

- The Provider/Practitioner’s agreement to participate in medical and other audits (e.g. Health Effectiveness Data and Information Set (HEDIS) and/or mandated) conducted by DHCS, other regulatory agencies, or MHC.
- The Provider/Practitioner’s agreement to maintain books and records for a period of seven (7) years and make such documents available to regulatory agencies and MHC.
- The Provider/Practitioner’s agreement to furnish MHC with encounter data. Providers/Practitioners are encouraged to review their contracts with MHC to become thoroughly familiar with these and additional performance requirements.

Compliance Reporting Requirements for IPAs/Medical Groups/Hospitals

MHC routinely monitors its network of delegated capitated IPAs/Medical Groups/Hospitals for compliance with various standards. These requirements include but are not limited to:

1. MHC requires the delegated capitated IPAs/Medical Groups/Hospitals to submit monthly claims timeliness reports. These reports are due to MHC by the 15th of each month for all claims processed in the previous month. 90% of claims are to be processed within thirty (30) calendar days of receipt. 100% of all claims are to be processed within forty five (45) working days. Refer to the Claims Section for MHC’s claim processing requirements MHC requires the delegated capitated IPAs/Medical Groups/Hospitals to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the IPA/Medical Group/Hospital does not achieve the timely processing requirements referenced above.
2. Claims Settlement Practices and Dispute Resolution Mechanism
 - a. MHC requires IPAs/Medical Groups/Hospitals to submit quarterly claims timeliness reports. These reports are due to MHC on or before the last calendar day of the month after the last month of each calendar quarter.
 - b. The Designated Principal Officer for Claims Settlement Practices must sign the Quarterly Claims Reports.
 - c. MHC also requires IPAs/Medical Groups/Hospitals to submit quarterly Provider Dispute Resolution Reports. These reports are also due on or before the last calendar day of the month after the last month of each calendar quarter.
 - d. The Designated Principal Officer for the Dispute Resolution Mechanism must sign the Quarterly Provider Dispute Resolution Reports.
 - e. These quarterly reports are due as follows:

<u>Calendar Quarter</u>	<u>Due Date</u>
First Quarter	April 30

Second Quarter	July 31
Third Quarter	October 31
Fourth Quarter	January 31

- f. MHC will conduct an annual PDR audit. More frequent audits will be conducted when the IPA/Medical Group/Hospital does not meet the PDR requirements.

3. Financial Reporting/Viability

- a. Quarterly financial statements are due to MHC within forty five (45) calendar days from the end of the IPA's/Medical Group's/Hospital's fiscal quarter. The quarterly financial statements need not be certified by outside auditors, but must be accompanied by a financial statement certification form signed by the Chief Financial Officer or President of the IPA/Medical Group/Hospital. Audited annual statements are due within one hundred twenty (120) calendar days, but no later than one hundred fifty (150) days, from the end of each IPA's/Medical Group's/Hospital's fiscal year. The audited annual statement must include footnote disclosures, and be prepared by an independent Certified Public Accountant in accordance with generally accepted accounting principles (GAAP).

All statements must be submitted on time, and meet SB 260 and MHC's viability standards: 1) current assets are greater than current liabilities and 2) tangible net equity is positive. Quarterly viability cannot be determined if the organization has not submitted their most recent annual audited statement.

In accordance with SB 260 (Financial Solvency Reporting), the IPA/Physician Group must also submit a quarterly financial survey report to the Department of Managed Health Care (DMHC) within forty five (45) calendar days from the end of the IPA/Physician Group's fiscal quarter.

The IPA/Physician Group must also submit an annual financial survey report to DMHC within one hundred fifty (150) calendar days from the end of the IPA/Physician Group's fiscal year.

The IPA/Physician Group must also submit a copy to MHC of their DMHC certification and/or financial survey which will show that the quarterly and/or annual survey has been completed on DMHC's web site. In addition, MHC will also review each IPA/Physician Group's cash-to-claims ratio, which is determined based on receivables collectable within sixty (60) days according to the Balance Sheet and Grading Criteria from the DMHC financial survey.

4. Utilization Management Reporting

- a. MHC requires capitated/delegated IPA/Medical Groups to submit utilization management reports in accordance with their Utilization Management Delegation Agreement.
- b. MHC's Delegation Oversight Department is responsible for systematic monitoring and annual audits of each delegated IPA/Medical Group and health plan partner to ensure their ability to perform delegated functions and adherence to all applicable regulatory and accreditation standards.

- c. In order to achieve and maintain delegation status for UM activities the delegate must demonstrate ongoing, functioning systems are in place and meet the required UM operational standards and reporting requirements.

MHC conducts its own Quality Improvement (QI) program. The IPA/Medical Groups and Providers/ Practitioners agree to abide by and participate in MHC's QI program.

Quality Oversight Monitoring

Under the terms of its contract with DHCS, MHC conducts ongoing reviews of Provider/Practitioner performance. Among the elements to be reviewed are the following:

- Conducts an annual or more frequent geo-access audit to determine geographic, PCP and Specialist gaps in the network. The data provides information for contracting strategies.
- MHC also conducts at least annual cultural, ethnic, racial and linguistic geo-access survey to assess availability of practitioners to meet the member's needs and determine network gaps. The data provides information for contracting strategies.
- MHC conducts an annual telephonic survey to review the time it takes members to access emergency care, urgent care, non-urgent (routine) care, specialty care, initial health assessments, first prenatal visits, physical exams, and wellness checks in accordance with access standards disclosed in Section 5, Access to Care.

Member Complaint and Grievance Indicators - Member concerns specific to the care and services of specific Providers/Practitioners are collected and acted upon by MHC's Member Services Department. Providers/Practitioners are engaged in the review of specific concerns and will be asked to assist in remedial endeavors, as indicated.

The outcomes and findings of the foregoing and other performance indicators are reviewed by MHC's Quality Improvement Department and by MHC's Quality Improvement Committee.

Quality Improvement Corrective Action Plans

When it is found that Providers/Practitioners or IPAs/Medical Groups do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this Manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans (CAP) will be forwarded to Providers/Practitioners and will include corrective actions and dates by which corrective actions are to be achieved.

MHC representatives will work with and offer support to Providers/Practitioners to ensure the timely resolution of CAP requirements.

Providers/Practitioners who fail to respond to an initial corrective action plan by the date specified will be provided a second iteration of CAP requirements; may be assigned an extended action plan due date and/or sign a document stating they have completed the CAP.

Non-Compliance with Quality Improvement Corrective Actions

MHC's Quality Improvement and/or Provider Services Departments coordinates and assists the Provider/Practitioner with the development and implementation of the corrective action plan.

Non-compliance with Quality Improvement corrective actions may result in any of the following:

- Contact by the MHC's Quality Improvement Department

- Conduct in-service/education
- Referral to the IPA or Medical Group for corrective action
- Implementation of Provider/Practitioner Compliance Department corrective action program which may result in the following sanctions:
 - The termination of new member enrollments
 - Moving current members to another IPA/Medical Group where the Provider/Practitioner is affiliated
 - Formal contract termination

Re-Audits

Re-audits are conducted to assure corrective actions have been effective in improving compliance with previously identified deficiencies.

DELEGATED IPAs AND MEDICAL GROUPS

MHC does not delegate any Quality Improvement Activities to any contracted Provider/Practitioner or IPA/Medical Group organization.

OVERSIGHT MONITORING OF UTILIZATION MANAGEMENT AND CREDENTIALING PROGRAMS FOR DELEGATED PROVIDERS

MHC may delegate responsibility for activities associated with utilization management (UM) and credentialing, to its IPAs/Medical Groups. Prior to approval of delegation, and at least annually thereafter, MHC conducts an onsite review of IPAs/Medical Groups requesting delegation. MHC uses delegation standards in compliance with NCQA, State and Federal Requirements. A member or designee of the delegation oversight team assigned to evaluate and oversee the IPAs/Medical Groups activities conducts the evaluation. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate peer review Committee may grant specific delegation functions to the IPA/Medical Group to perform. If approved for delegation, a delegation agreement must be executed between MHC and the IPA/Medical Group. A “Delineation of Responsibilities” grid is included with the Acknowledgement and Acceptance of Delegation Status, outlining the delegated activities; MHC’s Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; MHC’s Process for Evaluating Performance; and, Corrective Actions if the IPA/Medical Group fails to meet responsibilities.

MHC reserves the right to request corrective action plans or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA State and Federal Requirements.

Complex Case Management services are not delegated to IPAs/Medical Groups. MHC’s Medical Case Management Department retains sole responsibility for authorization and implementation of these services. IPAs/Medical Groups are required to refer known or potential cases to MHC Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

10.1 COMPLIANCE: PROVIDER EDUCATION

Provider education is implemented by Molina Healthcare of California (MHC) and its participating Medical Groups/Independent Physician Associations in counties where its applicable. Goals, objectives, curricula, and implementation guidelines are established by MHC. Where applicable, participating Medical Groups/IPAs are responsible for conducting provider training and orientation, and MHC provides additional resources and opportunities to supplement such trainings.

All newly contracted providers are required to receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. MHC and applicable Medical Group/IPA are required to conduct training for all providers within ten (10) working days after the newly contracted provider is placed on active status. MHC defines “active” status as the point at which the PCP is allowed to have membership assigned. Provider training includes but is not limited to:

- Provider/Practitioner Manual (MHC and/or Health Net for LA County only)
- Federal and State statutes and regulations to ensure provider’s full compliance and applicable policies and procedures.
- Web Portal Training
- Training on provider billing and reporting, including no balance billing information.
- Encounters, claims submission, appeals and grievances, and compensation information.
- Disability Awareness and Sensitivity Training regarding SPDs based on “Clinical Protocols and Practice Guidelines for Seniors and Persons with Disabilities/Chronic Conditions”
- Providers will be trained on a continuing basis regarding clinical protocols and evidenced-based practice guidelines for SPDs or chronic conditions. The training shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, information on MHC’s website as well as other methods of educational outreach to providers.
- Training on disability awareness and sensitivity, cultural and linguistic competency and location of resources for all members, including SPDs.
- Training on Model of Care, Coordination of Care, Behavioral Health services, LTSS, community supports and other Medicare Medicaid Plan/Cal MediConnect program requirements and ensure access is provided.
- Training on LTSS, including but not limited to, Community Based Adult Services, In Home Supportive Services, Multi-Purpose Senior Services Program and Skilled nursing facility/subacute care services. Training will include information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services.
- Distribution of Members Rights and Responsibilities, including the right to full disclosure of health care information and the right to actively participate in health care decisions.

MHC and applicable Medical Group/IPA are required to ensure ongoing training is conducted when deemed necessary.

10.2 COMPLIANCE: QUALITY IMPROVEMENT

QUALITY IMPROVEMENT PROGRAM

Purpose

The purpose of the Molina Healthcare of California (MHC) Quality Improvement Program is to establish methods for objectively and systematically evaluating and improving the quality of care and service provided to MHC members. MHC strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The MHC's Quality Improvement Program promotes a commitment to quality in every facet of the health plan's structure and processes. It relies on senior management oversight and accountability, and integrates the activities of all health plan departments in meeting the program's goals and objectives. The Quality Improvement Program involves all key stakeholders, members, participating practitioners, providers and health plan staff, in the development, evaluation and planning of quality improvement activities.

The MHC's Quality Improvement Program incorporates a continuous, quality improvement methodology that focuses on the specific needs of its internal and external customers. It is organized to identify and analyze significant opportunities for improvement in delivery of health care and service, to develop improvement strategies, and to track systematically, if these strategies result in progress toward benchmarks or goals. The methodology includes pursuing our goals in a culturally competent manner.

The written Quality Improvement Program defines the goals, objectives, scope, structure, committees and functions of the program. The Quality Improvement Program is reviewed and updated annually and presented to the Quality Improvement Committee (QI Committee) and to the Board of Directors for approval.

Scope of the Quality Improvement Program

The MHC Quality Improvement Program encompasses the quality of acute, chronic, and preventive clinical care and service provided in both the inpatient and outpatient setting by hospitals and facilities, participating provider groups, primary care and specialty practitioners, and ancillary providers.

Its specific focus includes:

1. The continuity and coordination of care.
2. The over-and-under-utilization of services.
3. The access to and availability of routine, urgent and, emergency care.
4. The health status of MHC members of all products.
5. Provider and practitioner qualifications and performance.
6. The environmental, physical, and clinical safety of MHC members.
7. The implementation of preventive health and clinical practice guidelines.
8. Member and practitioner satisfaction.

9. The effectiveness of health plan services including member education and services, practitioner relations and services, credentialing, utilization and case management, claims adjudication, risk management, and pharmacy management.
10. The ethnic and linguistic appropriateness of care and service.
11. Behavioral health services applicable for the Healthy Families product only. The services are managed by an NCQA accredited MBHO. These services are excluded from MHC's Medi-Cal contract
12. Assessing the effectiveness of quality improvement activities

PROVIDER/PRACTITIONER REVIEW PROCESS

Provider/Practitioner Facility Site Review (FSR)

- Effective July 1, 2002 the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool.
- All primary care sites serving Medi-Cal managed care members must undergo an initial site review and subsequent periodic site review every three (3) years using the current DHCS approved facility site review survey tool. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.
- The Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities to avoid duplication and overlapping of FSR reviews.
- All Primary Care Physicians must maintain an Exempted or Conditional pass on site review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about FSR requirements.

Medical Record Review (MRR)

- The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. MHC will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards.
- All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC provider network and at least every three (3) years thereafter.
- All Primary Care Physicians must maintain an Exempted or Conditional pass on medical record review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about MRR requirements.

Physical Accessibility Review Survey (PARS)

- In accordance to the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 11-013, managed care health plans are

required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists and ancillary providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The Physical Accessibility Review Survey (PARS) tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA).

- Unlike the Facility Site Review and Medical Records Review, PARS is a survey and no corrective action is required. Please refer to the Credentialing section of the Provider Manual for expanded information about PARS requirements.

Child Health and Disability Prevention (CHDP) Reviews

- The CHDP is a state preventive service program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.
- MHC provides health assessment, preventive health care and coordination of care to eligible members through the CHDP program.
- CHDP specific questions are incorporated into the Medical Record Review Tool. The CHDP review may be done concurrently with the medical record review.
- CHDP requirements are detailed in the Medical Record Pediatric Review Guidelines.

Comprehensive Perinatal Services Program (CPSP) Review

- The CPSP is designed to increase access to prenatal care and to improve pregnancy outcomes. The services of this program include health and nutrition education, psychosocial assessment, treatment planning, and periodic reassessment. CPSP must be offered to all MHC Medi-Cal members, but participation is voluntary. Refusal of CPSP must be documented in the patient's obstetrical record.

10.3 COMPLIANCE: FRAUD, WASTE, AND ABUSE PROGRAM

Molina Healthcare of California maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Molina Healthcare of California is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of California will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of California.

Mission Statement

Molina Healthcare of California regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare of California has therefore implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act (“DRA”) was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of California who receive or pay out at least \$5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing

business with Molina Healthcare of California, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer’s inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare of California contracted providers to ensure compliance with the law.

Definitions

Fraud:

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Waste:

Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

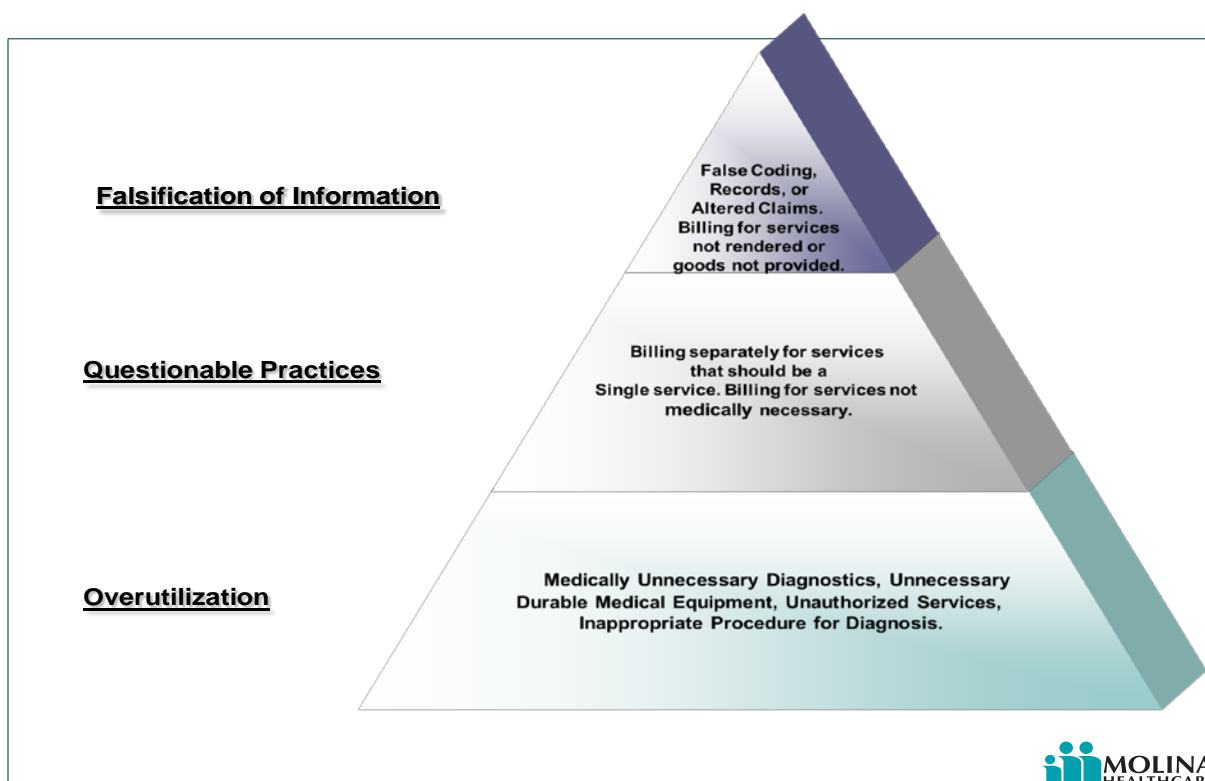
Abuse:

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in

reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding", and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of California identification card.
- Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)



Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities including the OIG List of Excluded Individuals/Entities
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of state Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider/Practitioner Education

When Molina Healthcare of California identifies through an audit or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, Molina Healthcare of California may determine that a provider/practitioner education visit is appropriate.

The Molina Healthcare of California Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina Healthcare Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claims payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina Healthcare of California performs auditing to ensure the accuracy of data input into the claims system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide

them to the Molina Healthcare Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at <https://molinahealthcare.alertline.com>

You may also report cases of fraud, waste or abuse to Molina Healthcare of California's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of California
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the state at:

California Department of Health Care Services
Toll Free Phone: 1-800-822-6222

10.4 COMPLIANCE: HIPAA REQUIREMENTS & INFORMATION

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare (MHC) takes very seriously. MHC is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI). MHC provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how MHC uses and discloses their PHI and includes a summary of how MHC safeguards their PHI. A sample of MHC's privacy notice is enclosed at the end of this section.

Provider/Practitioner Responsibilities

Providers play a key role in safeguarding PHI pertaining to MHC Members. MHC expects that its contracted Providers/Practitioners will respect the privacy of MHC members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/Practitioners must comply with. In general, most healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
 - a. HIPAA
 - b. Medicare and Medicaid laws
2. Applicable State California Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider/Practitioner's own TPO activities, but also for the TPO of another covered entity¹ Disclosure of PHI by one covered entity to another covered entity, or healthcare

provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that —"payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of —"services."²
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
 - a. Quality improvement
 - b. Disease management;
 - c. Case management and care coordination;
 - d. Training Programs;
 - e. Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with MHC for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. MHC Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner's practice:

1. *Notice of Privacy Practices*

Providers/Practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. *Requests for Restrictions on Uses and Disclosures of PHI*

Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

¹ See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule

² See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

3. *Requests for Confidential Communications*

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

4. *Requests for Patient Access to PHI*

Patients have a right to access their own PHI within a Provider/Practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider/Practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. *Request to Amend PHI*

Patients have a right to request that the Provider/Practitioner amend information in their designated record set.

6. *Request Accounting of PHI Disclosures*

Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to MHC.

HIPAA Transactions and Code Sets

MHC strongly supports the use of electronic transactions to streamline healthcare administrative activities. MHC Providers/Practitioners are encouraged to submit claims and other transactions to MHC using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

MHC is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with MHC should refer to MHC's website at: www.MolinaHealthcare.com for additional information.

Click on the tab titled “Providers,” select a state, click the tab titled “HIPAA” and then click on the tab titled “TCS readiness.”

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to MHC and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to MHC within thirty (30) days of the change. Provider/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to MHC.

Additional Requirements for Delegated Providers/Practitioners

Providers/Practitioners that are delegated for claims and utilization management activities are the “business associates” of MHC. Under HIPAA, MHC must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

National Provider Identifier



Your Privacy

Dear Molina Healthcare of California Partner Plan, Inc. (Molina Healthcare) Member:

Your privacy is important to us. We respect and protect your privacy. Molina Healthcare uses and shares your information to provide you with health benefits. Molina Healthcare wants to let you know how your information is used or shared.

Your Protected Health Information

PHI stands for these words, *protected health information*. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Does Molina Healthcare use or share our members' PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

Does Molina Healthcare need your written authorization (approval) to use or share your PHI?

Molina Healthcare needs your written approval to use or share your PHI for purposes not listed

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use it.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI. Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

Our Notice of Privacy Practices has more information about how we use and share our members' PHI. Our Notice of Privacy is in the following section and is on our web site at www.MolinaHealthcare.com. You may also get a copy of our Notice of Privacy by calling our Member Services Department at (888) 665-4681.

**NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF CALIFORNIA PARTNER PLAN, INC.**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

California Partner Plan, Inc. ("Molina" or "we") provides health care benefits to you through the Medi-Cal program. Molina uses and shares protected health information about you to provide your health care benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is March 1, 2013.

PHI stands for these words, protected health information. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

We use or share your PHI to provide you with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment.

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

Payment.

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations.

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve member concerns. Your PHI may also be used, to see that claims are paid right.

Health care operations involve many daily business needs. It includes, but is not limited to, the following:

- Improving quality
- Actions in health programs to help members with certain conditions (such as asthma)
- Conducting or arranging for medical review
- Fraud and abuse programs
- Actions to help us obey laws.
- Address member needs, including solving complaints and grievances.

We will share your PHI with other companies ("business associates") that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use it PHI to give you information about other treatment, or other health-related benefits and services.

When can MHC use or share your PHI without getting written authorization (approval) from you?

The law allows or requires MHC to use and share your PHI for several other purposes including:

Required by law.

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health.

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight.

Your PHI may be used or shared with government agencies. They may need your PHI to check how our health plan is providing services.

Legal or Administrative Proceedings.

Your PHI may be shared with a court, investigator or lawyer if it is about the operation of Medi-Cal. This may involve fraud or actions to recover money from others, when the Medi-Cal program has provided your health care benefits.

When does MHC need your written authorization (approval) to use or share your PHI?

MHC needs your written approval to use or share your PHI for purposes other than those listed in this notice. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**

You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request.

- **Request Confidential Communications of PHI**

You may ask MHC to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use MHC's form to make your request.

- **Review and Copy Your PHI**

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a MHC member. You will need to make your request in writing. You may use MHC's form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request.

Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

- **Amend Your PHI**

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use MHC's form to make your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of your PHI)**

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with your authorization;
- incident to a use or disclosure otherwise permitted or required under applicable law;
- as part of a limited data set in accordance with applicable law; or shared prior to April 14, 2003.

We will charge a reasonable fee for each list if you ask for this list more than once in a 12 month period. You will need to make your request in writing. You may use MHC's form to make your request. You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Director of Member Services at 1-888-665-4621.

Do I Complain?

If you believe that we have not protected your privacy and wish to complain, you may file a complaint (or grievance) by calling or writing us at:

Molina Healthcare of California Partner Plan, Inc. Member Services (888) 665-4621

We will not do anything against you for filing a complaint. Your care will not change in any way.

OR you may call, write or contact the agencies below:

Privacy Officer

c/o: Office of Legal Services
California Department of Health Care Services
P.O. Box 997413, MS 0011
Sacramento, CA 95899-7413 (916) 440-7700
Email: privacyofficer@dhcs.ca.gov

Secretary of the U.S. Department of Health and Human Services

Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
(415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX

What are the duties of Molina?

MHC is required to:

- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of this Notice

This Notice is Subject to Change - Changing information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

If you have any questions, please contact the following:

Member Services
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone: (888) 665-4621

11.0 CREDENTIALING: FACILITY SITE REVIEW

The facility site review (FSR) is a comprehensive evaluation of the facility, administration and medical records to ensure conformance to the California Department of Health Care Services (DHCS) and regulatory agency standards. The review and certification of Primary Care Practitioner (PCP) sites are required for all health plans participating in the Medi-Cal managed care program (Title 22, CCR, Section 56230). The California statute requires that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified and compliant with all applicable DHCS standards. Furthermore, facility site reviews are required as part of the credentialing process, according to the provision of Title 22, CCR, Section 53856.

A PCP is defined as a General Practitioner, an Internist, a Family Practitioner, Obstetrician/Gynecologist (OB/GYN) who meets the requirements for PCP, or a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services.

Facility Site Review Process

Effective July 1, 2002 the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool. This is found in Medi-Cal Managed Care Division (MMCD) Policy Letter 02-002 and includes, but is not limited to, any relevant superseding policy letters.

In efforts to avoid duplication and overlapping of FSR reviews, the Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities. One (1) site review conducted by a participating collaborative Medi-Cal managed care health plan will be accepted by other Medi-Cal managed care health plans. This will establish **ONE** (1) certified FSR and MRR that the participating PCP site will need to pass and be eligible with all the Medi-Cal Health Plans in a given county.

Standardized DHCS Facility Site Review Tool is comprised of three (3) components:

- Attachment A: Facility Site Review Tool
- Attachment B: Medical Record Review Tool
- Attachment C: Physical Accessibility Review Survey

Initial Full Scope Review

All primary care sites serving Medi-Cal managed care members must undergo an initial site review with attainment of a minimum passing score of 80% on the site review and medical record review. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a full scope survey within the past three (3) years with a passing score. The initial full scope site review survey can be waived by a managed care health plan for a pre-contracted physician site if the physician has a documented proof of current full scope survey,

conducted by another Medi-Cal managed care health plan within the past three (3) years. MHC follows the same procedures as for an initial site visit when a PCP relocates or opens a new site.

Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conducting the subsequent full scope site survey is three (3) years. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

Medical Record Review

The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. Molina Healthcare of California (MHC) will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards. All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC provider network and at least every three (3) years thereafter. Ten (10) medical records are reviewed for each physician. Sites where documentation of patient care by multiple PCPs occurs in the same medical record will be reviewed as a “shared” medical record system. Shared medical records are those that are not identifiable as “separate” records belonging to any specific PCP. A minimum of ten (10) records will be reviewed if two (2) to three (3) PCPs share records, twenty (20) records will be reviewed for four (4) to six (6) PCPs, and thirty (30) records will be reviewed for seven (7) or more PCPs.

Physical Accessibility Review Survey (PARS)

In accordance to the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 11-013, managed care health plans are required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists and ancillary providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). PARS consist of 86 criteria, which include 29 designated critical access elements. Based on the outcome of the PARS review, each site is designated as having either Basic Access or Limited Access, along with the six specific accessibility indicator designations for parking, exterior building, interior building, restrooms, examination rooms, and medical equipment. Unlike the Facility Site Review and Medical Records Review, **PARS is a survey and no corrective action is required.**

SCORING

All Primary Care Physicians must maintain an Exempted or Conditional pass on site review and medical record review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS.

Compliance & Corrective Action Plan (CAP)

Facility Site Review Score Threshold

Exempted: A performance score of 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control sections of the review tool
A Corrective Action Plan is not required

Conditional: A performance score of 80% - 90% *or* 90% and above with deficiencies in Critical Elements, Pharmaceutical or Infection Control sections of the review tool
A Corrective Action Plan is required

Not Pass: Below 80% performance score

Medical Record Review Score Threshold

Exempted: A performance score of 90% to 100%; any section score of less than 80% will require a Corrective Action Plan for the entire medical records reviewed, regardless of the total score

Conditional: A performance score of 80% to 89%
A Corrective Action Plan is required

Not Pass: Below 80% performance score

Physicians with an Exempted Pass Score

All reviewed sites that score 90% to 100% on the facility site review survey *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control sections of the review tool do not need to submit a CAP.

All reviewed sites that score 90% to 100% and greater than 80% on each section scores of the medical record review survey do not need to submit a CAP. Any section score of less than 80% in the medical record review survey requires submission of completed CAP, regardless of the aggregated MRR score.

Physicians with a Conditional Pass Score

A score of 80% to 89% or 90% and above with deficiencies in Critical Element, Pharmaceutical or Infection Control sections of the review tool must complete and submit a CAP.

- Critical Element CAP must be completed and submitted within ten (10) business days from the date of the review.
- CAP must be completed and submitted within forty-five (45) calendar days from the date of the review.

A score of 80% to 89% of the medical record review survey must complete and submit a CAP. The CAP must be submitted within forty-five (45) calendar days from the date of the review.

Physicians with a Not Pass Score

A score of 79% or below will not have new members assigned until appropriate and necessary CAP is completed and all deficiencies are corrected and verified. The CAP must be completed, submitted timely, fully accepted, and verified or a follow-up visit must be conducted for a focused review with a passing score.

In compliance to the Department of Health Care Services, Medi-Cal Managed Care Division Policy Letter 02-02, physicians and sites with Not Pass scores must be notified to all Medi-Cal Managed Care Health Plans in the county.

CAP Extension

No timeline extensions are allowed for Critical Element CAP completion. A physician may request a definitive, time-specific extension period that does not exceed ninety (90) calendar days from the date of the review. The request shall be submitted through a formal written explanation of the reason(s) for the extension and submitting the completed portions of the CAP within the forty-five (45) calendar day timeframe.

No extension beyond ninety (90) calendar days from the date of the review can be granted by the health plan. Any extension beyond ninety (90) calendar days requires an approval from the Department of Health Care Services.

NOTE: AN EXTENSION FOR CAP COMPLETION BEYOND NINETY (90) DAYS REQUIRES THAT THE SITE VISIT BE RESURVEYED WITHIN TWELVE (12) MONTHS OF THE INITIAL SURVEY.

CAP Completion

Physicians or their designees can complete the CAP:

- Review and correct the identified deficiencies in Column Two (2) and Column Three (3) of the CAP form.
- Review and implement the recommended corrective actions in Column Four (4) of the CAP form and provide appropriate attachments or documents that address the deficiencies.
- Enter the date of completion or implementation of the corrective action in Column Five (5) of the CAP form.
- Document specific comments on implemented activities to address and satisfy the corrective action(s) and document a responsible designee's initials in Column Six (6) of the CAP form.
- Document the signature and the title of the physician or the designee who is responsible for completing the CAP in Column Seven (7) of the CAP form.
- Upon implementation, completion and documentation of the entire corrective action items identified on the CAP form, submit the completed CAP form.

CAP Submission

The physician, at his/her discretion, may involve any or all IPAs/Medical Groups or management companies with which the physician is contracted to assist in completion of the CAP.

The CAP must be submitted directly to the Site Reviewer of the health plan.

Identification of Deficiencies Subsequent to an Initial Site Visit

Any MHC Director or Manager shall refer concerns regarding member safety and/or quality of care issues to appropriate Department(s) for necessary follow-up activities.

Member complaints related to physical office site(s) are referred to appropriate MHC Department(s) for subsequent investigation that may include performing an unannounced onsite facility review and follow-up of any identified corrective actions.

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) REVIEW OF MOLINA HEALTHCARE'S PERFORMANCE OF FACILITY SITE REVIEWS

Review Process

An oversight audit of MHC and contracted physicians and facilities will be conducted by the DHCS.

- These visits may be conducted with or without prior notification from the DHCS.

If a prior notification is given, the sites selected by the DHCS for oversight reviews will be contacted to arrange a visit schedule by either the DHCS auditor or MHC.

MHC will provide any necessary assistance required by the DHCS in conducting facility oversight evaluations.

Requirements and Guidelines for Facility Site

Complete and comprehensive requirements, standards, and guidelines are found in *Facility Site Review Tool* and *Facility Site Review Guideline*.

Please visit MHC website at: www.MolinaHealthcare.com to review these documents.

Requirements and Guidelines for Medical Record Documentation (applies to both adults and children)

Complete and comprehensive requirements, standards, and guidelines are found in *Medical Record Review Tool* and *Medical Record Review Guideline*.

Please visit MHC website at: www.MolinaHealthcare.com to review these documents.

Information Available to Providers on MHC Website

In efforts to assist our providers, there are many resources and topics that are relevant to Facility Site Review and Medical Records Review processes and guidelines. Please visit MHC website to access these materials and information:

- Facility Site Review Tool and Guidelines
- Medical Record Review Tool and Guidelines
- Interim Review of Critical Elements at 18 months
- FSR Attachment C: Physical Accessibility Review Survey (PARS)
- Frequently used facility forms and log sheets
- Frequently used Medical Record forms and documentations
- Preventive Health Guidelines
- Staying Healthy Assessment forms
- Clinical Practice Guidelines

11.1 CREDENTIALING: CREDENTIALING & RECREDENTIALING

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare of California (MHC) network consists of quality practitioners/providers who meet clearly defined criteria and standards. It is the objective of MHC to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary and secondary source verifications, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law. The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, MHC Members will not be referred and/or assigned to you until the credentialing process has been completed.

CRITERIA FOR PARTICIPATION IN THE MOLINA NETWORK

MHC has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the MHC network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the MHC network.

MHC reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by MHC.

Practitioners should adhere strictly to the ethics of the profession, have demonstrated a temperament and ability to work cooperatively with others free of evidence of a disruptive personality, and be willing to participate in the provision of cost effective and quality services in the managed care environment, including but not limited to the discharge of MHC responsibilities.

Practitioners must meet the following criteria to be eligible to participate in the MHC network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the MHC network.

Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Practitioner must practice, or plan to practice within 90 calendar days, within the area served by MHC.
2. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for MHC members.
3. Practitioner must have current professional malpractice liability coverage with limits that meet MHC criteria specifically outlined in Addendum B of this policy.

4. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.
5. Dentists, Oral Surgeons, Physicians (MDs, DOs) and Podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice when providing service to MHC members. Adequate training must be demonstrated by one of the following:
 - a. Current Board Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM), or the American Board of Oral and Maxillofacial Surgery
 - b. Successful completion of a residency or fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United states or by the College of Family Physicians in Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA)
6. Practitioners who are not Board Certified as described in section 5a above and have not completed an accredited Residency program are only eligible to be considered for participation as a General Practitioner in the MHC network. To be eligible as a General Practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
7. At the time of initial application, the practitioner must not have any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body.¹
8. Practitioner must not be currently excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
9. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
10. Practitioners not able to practice independently according to state law (e.g. NP's, Midwives, PA-C's) must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with MHC.

¹ If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

11. Physicians, Primary Care Practitioners, Midwives, Oral Surgeons and Podiatrists must have admitting privileges in their specialty with MHC contracted hospitals or have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed MHC participating practitioner that has the ability to admit MHC patients to a MHC contracted hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges.
12. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/Gyn. contracted and credentialed with MHC. This arrangement must include 24-hour coverage and inpatient care for MHC members in the event of emergent situations. Family Practitioners providing obstetric care may provide backup in rural areas that do not have an OB/Gyn. Backup physician must be located within 30 minutes from midwives practice.
13. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day.
14. MHC may determine, in its sole discretion that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by MHC, who is currently in the Fair Hearing Process, or who is under investigation by MHC. MHC also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by MHC. For purposes of these criteria, a company is “owned” by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means. Practitioner’s denied or terminated by the Credentialing Committee are not eligible to reapply until one year after the date of denial or termination by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.

A. Burden of Proof

The practitioner shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the MHC network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the MHC network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the MHC network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

B. Practitioner Termination and Reinstatement

If a practitioner’s contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if the break in service is more than 30 calendar days. The credentialing factors that are no longer within the credentialing time

limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to practitioner's reentry into network.

If a practitioner is given administrative termination for reasons beyond MHC's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, MHC may recredential the practitioner as long as there is clear documentation that the practitioner was terminated for reasons beyond MHC's control and was recredentialed and reinstated within 30 calendar days of termination. MHC must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

If MHC is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical; but the contract between MHC and the practitioner remains in place, MHC will recredential the practitioner upon his or her return. MHC will document the reason for the delay in the practitioner's file. At a minimum, MHC will verify that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, MHC will complete the recredentialing cycle. If either party terminates the contract or there is a break in service of more than 30 calendar days, MHC will initially credential the practitioner before the practitioner rejoins the network.

C. Practitioners Terminating with a Delegate and Contracting with MHC Directly

Practitioners credentialed by a delegate who terminate their contract with the delegate and want to contract with MHC directly must be credentialed by MHC within six-months of the practitioner's termination with the delegate. If the practitioner has a break in service more than 30 calendar days, the practitioner must be initially credentialed prior to reinstatement.

D. Credentialing Application

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide MHC with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. MHC may use another organization's application as long as it meets all the factors outlined in this policy. MHC will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage
- The correctness and completeness of the application

Inability to Perform Essential Functions and Illegal Drug Use

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. MHC may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of Actions against Applicant

An application must contain the following information:

- History of loss of license
- History of felony convictions
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges

Current Malpractice Coverage

The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. MHC may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For practitioners with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Practitioner files that include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage are acceptable.

Correctness and Completeness of the Application

Practitioners must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to MHC is used, it must include an attestation to the correctness and completeness of the application. MHC does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state regulations require MHC to use a credentialing application that does not contain an attestation, MHC must attach an addendum to the application for attestation.

Meeting Application Time Limits

If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the practitioner to update the attestation.

THE PROCESS FOR MAKING CREDENTIALING DECISIONS

All practitioners requesting initial participation with MHC must complete a credentialing application. To be eligible to submit an application, practitioners must meet all the criteria outlined above in the section titled "Criteria for Participation in the MHC Network." Practitioners may not provide care to MHC members until the final decision is rendered by the Credentialing Committee or the MHC Medical Director.

MHC recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, a request will be sent to the practitioner requesting completion of a recredentialing application.

During the initial and recredentialing application process, the practitioner must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last 180 calendar days
- Provide MHC adequate information to prove he/she meets all criteria for initial participation or continued participation in the MHC network.

Once the application is received, MHC will complete all the verifications as outlined in the attached Practitioner Criteria and Primary Source Verification Table. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the MHC network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by MHC must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and MHC will discontinue processing of the application. This will result in an administrative denial or termination from the MHC network. Practitioners who fail to provide proof of meeting criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the MHC Credentialing Committee.

At each Credentialing Committee meeting, practitioner credentials files assigned a Level 2 are reviewed by the Credentialing Committee. All of the issues are presented to all the Credentialing Committee members and then open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final decision. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

PROCESS FOR DELEGATING CREDENTIALING AND RECREDENTIALING

MHC will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet MHC's requirements for delegation. MHC's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet MHC's requirements.

MHC's Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in MHC Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass MHC's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90%.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by MHC at pre-assessment
- Agree to MHC's contract terms and conditions for credentialing delegates
- Submit timely and complete reports to MHC as described in policy and procedure
- Comply with all applicable federal and state laws
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation.

NON-DISCRIMINATORY CREDENTIALING AND RE-CREDENTIALING

MHC does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the practitioner specializes. This does not preclude MHC from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

NOTIFICATION OF DISCREPANCIES IN CREDENTIALING INFORMATION

MHC will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license, malpractice claims history or board certification decisions. MHC is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

NOTIFICATION OF CREDENTIALING DECISIONS

A letter is sent to every practitioner with notification of the Credentialing Committee or Medical Director decision regarding their participation in the MHC network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the practitioner's credentials files. Under no circumstance will notifications letters be sent to the practitioners later than 60 calendar days from the decision.

CONFIDENTIALITY

All practitioner information obtained during the credentialing process is private and confidential except where otherwise specified by law or at the discretion of the Credentialing Committee or the MHC Board. This policy includes both voting and non-voting members of the Credentialing Committee, invited guests of the Credentialing Committee and MHC Credentialing staff who is involved in the data collection and file preparation for the credentialing and recredentialing process.

Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee or the MHC Board, in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at MHC.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of MHC. Each person is given a unique user ID and password. It is the strict policy of MHC that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and MHC Staff is instructed not to divulge passwords to their co-workers.

PRACTITIONERS RIGHTS TO REVIEW THEIR CREDENTIALING FILE

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents which the practitioner sent to MHC (e.g., the application, the license and a copy of the DEA certificate). Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board), and verification of hospital privileges letters.

PRACTITIONERS RIGHT TO CORRECT ERRONEOUS INFORMATION

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

MHC will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license or malpractice claims history. MHC is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to the practitioner will detail the information in question and will include instructions to the practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from MHC.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The practitioner's response must be sent to Molina Healthcare, Inc. Attention Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, MHC will document receipt of the information in the practitioners credentials file. MHC will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioners credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to MHC's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be denied.

PRACTITIONERS RIGHT TO BE INFORMED OF APPLICATION STATUS

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by MHC and are notified of their right to be informed of the status of their application in this letter.

The practitioner can request to be informed of the status of their application by telephone, email or mail. MHC will respond to the request within two working days. MHC may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. MHC does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.

CREDENTIALING COMMITTEE

MHC designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. MHC works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to MHC members. A practitioner may not provide care to MHC members until the final decision from the Credentialing Committee or in situations of “clean files” the final decision from the MHC Medical Director.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network practitioners, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee member shall be immune, to the fullest extent provided by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee members. Each member is required to meet all of MHC’s credentialing criteria. Credentialing Committee members must be current representatives of MHC’s practitioner network. The Credentialing Committee representation includes at least five practitioners, one practitioner from each of the following specialties:

- Family Practice or Internal Medicine or General Practice
- Pediatrics
- OB/GYN
- Specialist

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc practitioners may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Practitioner, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

- Committee members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by MHC on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final decisions regarding credentialing determinations and disciplinary actions.
- Conduct ongoing monitoring of those practitioners approved to be monitored on a "watch status"
- Access clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with MHC's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

EXCLUDED PRACTITIONERS

Excluded practitioner means an individual practitioner, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, MHC and its subcontractors may not subcontract with an Excluded Practitioner/Person. MHC and its subcontractors shall terminate subcontracts immediately when MHC and its subcontractors become aware of such excluded practitioner/person or when MHC and its subcontractors receive notice. MHC and its subcontractors certify that neither it nor its member/practitioner is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where MHC and its subcontractors are unable to certify any of the statements in this certification MHC and its subcontractors shall attach a written explanation to this Agreement.

PRACTITIONERS/PROVIDERS OPTING OUT OF MEDICARE

If a practitioner/provider opts out of Medicare, that practitioner/provider may not accept Federal reimbursement for a period of two (2) years. Practitioners/Providers who are currently opted out of Medicare are not eligible to contract with MHC for the Medicare line of business.

ONGOING MONITORING OF SANCTIONS

MHC monitors practitioner sanctions between recredentialing cycles for all practitioner types and takes appropriate action against practitioners when occurrences of poor quality is identified.

Medicare and Medicaid Sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, MHC reviews the report and if a MHC network provider is found with a sanction, the practitioner's contract is terminated effective the same date the sanction was implemented.

Sanctions or Limitations on Licensure

MHC monitors for sanctions or limitations against licensure between credentialing cycles for all network practitioners. All practitioners with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Continuous Query (Proactive Disclosure Service)

MHC registers all network practitioners with the NPDB/HIPDB Continuous Query program. MHC receives instant notification of all new NPDB and HIPDB reports against the enrolled providers. When a new report is received between recredentialing cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Medicare Opt-Out

Practitioner's participating in Medicare must not be listed on the Medicare Opt-Out report. MHC reviews the quarterly opt out reports released from the appropriate Medicare financial intermediary showing all of the practitioners who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. These provider contracts will be immediately terminated for the MHC Medicare line of business.

RANGE OF ACTIONS, NOTIFICATION TO AUTHORITIES AND PRACTITIONER APPEAL RIGHTS

MHC uses established criteria in the review of practitioners' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of Actions Available

The MHC Credentialing Committee can take one of the following actions against practitioners who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all practitioners who are contracted by MHC. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of MHC practitioners.

If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a practitioner from the MHC network include, but are not limited to, the following:

1. The practitioner's professional license in any state has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Practitioner has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the practitioner's acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to MHC members.

4. Practitioner has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner's practice.
6. Practitioner has ever had sanctions of any nature taken by any governmental program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency
7. Practitioner has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Practitioner's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Practitioner has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the practitioner's professional conduct or the health, safety or welfare of MHC members
11. Practitioner has ever engaged in acts which MHC, in its sole discretion, deems inappropriate.
12. Practitioner has a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to MHC members.
13. Practitioner has not complied with MHC's quality assurance program.
14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Practitioner has displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Practitioner makes any material misstatements in or omissions from their credentialing application and attachments.
17. Practitioner has ever rendered services outside the scope of their license.
18. Practitioner has a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Practitioner's failure to comply with the MHC Medical Record Review Guidelines.
20. Practitioner's failure to comply with the MHC Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

MHC uses the credentialing category "watch status" for practitioners whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a practitioner to be monitored on watch status when there

are unresolved issues or when the Credentialing Committee determines that the practitioner needs to be monitored for any reason.

When a practitioner is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the MHC Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and determination.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, MHC may work with the practitioner to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Practitioners subject to corrective action will be notified within ten (10) calendar days, via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to patients, a meeting will be held immediately with MHC Legal Counsel, the Medical Director and the Director of Credentialing. After discussing the facts, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension, via a certified letter.

Notification will include the following:

- The action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the practitioner
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Termination

After review of appropriate information, the Credentialing Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the practitioner. The effective date of the termination is determined by the contractual agreement between MHC and the affected practitioner.

Within ten (10) calendar days of the Committee's decision, the practitioner is sent written notice of termination, via a certified letter from the Medical Director, which includes the following:

- Effective date of termination
- Reason for termination
- Obligations of the practitioner regarding further care of MHC patients/members
- If applicable, details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Notification to Authorities

MHC will make reports to appropriate authorities as specified in the Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Practitioner based upon Unprofessional Conduct including:

- Revocation, termination of, or expulsion from MHC Provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by MHC that by its nature is reportable to the State Licensing Board, the NPDB, and/or HIPDB.

If a Fair Hearing is offered, a certified letter is sent to the practitioner describing the adverse action taken, the reason for the action and notifying the practitioner of their right to a Fair

Hearing. A copy of the Fair Hearing Plan Policy is included with the letter. The practitioner is given 30 calendar days to request a Fair Hearing. The practitioner is notified of their right to be represented by an attorney or another person of their choice.

If the practitioner requests a Fair Hearing, the MHC Fair Hearing Plan Policy is followed. A hearing officer is appointed and a panel of individuals appointed by MHC to review the appeal.

Once the hearing is completed, a written notification of the appeal decision will be sent to the practitioner who will contain the specific reason for the decision.

Within 15 calendar days of the effective date of the action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

FAIR HEARING PLAN POLICY

Under State and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board, the National Practitioner Data Bank (“NPDB”), and/or the Healthcare Integrity and Protection Data Bank (“HIPDB”).

Molina Healthcare, Inc., and its affiliates (“Molina”), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board, NPDB, and/or HIPDB.

A. Definitions

1. Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (1)-(3) below.
2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina affiliate state plan wherein the Provider is contracted.
3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
4. Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the Provider is contracted.
5. Molina Plan shall mean the respective Molina affiliate state plan wherein the Provider is contracted.
6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
8. Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the Provider is contracted.
9. Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).

10. State shall mean the licensing board in the state in which the provider practices.
11. State Licensing Board shall mean the state agency responsible for the licensure of Provider.
12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.
2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina members.
3. Any other final action by Molina that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.

C. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;
2. State any Credentialing Policy provisions that have been violated;
3. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
4. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
5. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
6. Advise the Provider that the request for a hearing *must* be accompanied by a check in the amount of \$1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and
8. Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing

Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the Provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

- a. Evaluate evidence and testimony presented.
- b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
- c. Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives.

The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

- a. Exclude any witness, other than a party or other essential person.
- b. Determine the attendance of any person other than the parties and their counsel and representatives.
- c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

- a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
- b. Ensure that proper decorum is maintained;
- c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
- d. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;
- e. Issue rulings on any objections or evidentiary matters;
- f. Discretion to limit the amount of time;
- g. Assure that each witness is sworn in by the court reporter;
- h. May ask questions of the witnesses (but must remain neutral/impartial);
- i. May meet in private with the panel members to discuss the conduct of the hearing;
- j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
- k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
- l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give

notice to the affected Provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

H. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.
4. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The Provider shall have the following pre-hearing rights:
 - a. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
 - b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.
2. The Hearing Committee shall have the following pre-hearing right:
 - To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
 - a. Whether the information sought may be introduced to support or defend the charges;
 - b. The exculpatory or inculpatory nature of the information sought, if any;
 - c. The burden attendant upon the party in possession of the information sought if access is granted; and
 - d. Any previous requests for access to information submitted or resisted by the parties.
4. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.
5. It shall be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

- a. Call and examine witnesses for relevant testimony.
- b. Introduce relevant exhibits or other documents.
- c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
- d. Otherwise rebut evidence.
- e. Have a record made of the proceedings.
- f. Submit a written statement at the close of the hearing.
- g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The Provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

- a. Each party may make an oral opening statement.
 - b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
 - c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
 - d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
 - e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.
3. Use of Exhibits
- a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
 - b. A description of the exhibits in the order received shall be made a part of the record.
4. Witnesses
- a. Witnesses for each party shall submit to questions or other examination.
 - b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
 - c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
 - d. The party producing such witnesses shall pay the expenses of their witnesses.
5. Rules for Hearing:
- a. Attendance at Hearings
Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.
 - b. Communication with Hearing Committee
There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.
 - c. Interpreter
Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
 - a. The panel members' names and specialties;
 - b. The Hearing officer's name;
 - c. The date of the hearing;
 - d. The charges at issue; and
 - e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party

requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, and offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected Provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by this Policy before resorting to legal action.

12.0 DEFINITIONS

Abuse - provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Aid to Families with Dependent Children (AFDC) - A program offered by the State of California that provides cash grants, food coupons, and medical benefits for low income families.

Appeal - An appeal is a request for reconsideration of a determination for authorization of a service or the denial of a claim.

Authorization - Approval requested and obtained by Providers/Practitioners for designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Beneficiary Identification Card (BIC) - A permanent plastic card issued by the State to recipients of entitlement programs which can be used by contractors to verify health plan eligibility. Files are updated monthly, as well as daily in special circumstances.

California Children Services (CCS) - A State and County program providing medically necessary specialized medical care and rehabilitation to persons under 21 years of age (as defined in Title 22, CCR, Section 41800) who meet medical, financial, and residential eligibility requirements for the CCS program.

Child Health and Disability Prevention Program (CHDP) - Preventive well-child screening program for eligible beneficiaries under 21 years of age provided in accordance with the provisions of Title 17, CCR, Section 6800 et seq. Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and the Prenatal Guidance Program.

Central Issuance Division (CID) - A unit at DHCS that reports for eligibility data systems.

Claim - A request for payment for the provision of Covered Services prepared on a CMS 1500 form, UB04, PM160 for CFDP Services or successor.

Clean Claims - A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Community Based Adult Services (CBAS) - Licensed Centers provide health and social services as an alternative to institutionalization and a safe and therapeutic environment with eligible conditions. CBAS includes nursing and therapeutic care for the member who may have a physical or mental impairment that handicaps daily activities but who does not require institutionalization.

Comprehensive Perinatal Services Program (CPSP) - A State sponsored program developed to provide quality health care for women during and surrounding pregnancy by encouraging evaluation in obstetrical, nutritional, social, and educational spheres to assess and address high risk conditions.

Contracting Provider - A physician, nurse, technician, hospital, home health agency, nursing home, or any other individual or institution contracted to provide medical services to health plan members.

Conviction (or convicted) - A judgment of conviction has been entered by a Federal, State or local court regardless of whether an appeal from that judgment is pending (42CFR 455.2). This definition also includes the definition of the term “convicted” in Welfare and instructions Code Section 14043.1(f)

Covered Services - Those healthcare services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Plan product which covers the Member.

Credentialing - The verification of applicable licenses, certifications, and experience to assure that Provider/Practitioner status be extended only to professional, competent Providers/Practitioners who continuously meet the qualifications, standards, and requirements established by MHC.

Department of Managed Health Care (DMHC) - The State department responsible for administering the Knox Keene Act of 1975. Knox Keene established the DMHC as the legally designated State regulatory agency for managed health care organizations.

Department of Health Care Services (DHCS) - The State department solely responsible for administration of the Medi-Cal, CPSP, CCS, CHDP, and other health related programs.

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

Direct PCP - A Primary Care Practitioner (PCP) that holds a contract with MHC.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program - The initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program as set forth in Title 17, CCR, Sections 6800 et seq. The program consists of

periodic and episodic screening services, diagnostic and treatment services, and supplemental services, including case management services.

Eligible Beneficiary - Any Medi-Cal beneficiary who resides in the contractor's service area and who falls into one or more of the following categories (with a specific aid code): Aid to Families with Dependent Children, Medically Needy Family, Public Assistance Aged, Medically Needy Aged, Public Assistance Blind, Medically Needy Blind, Public Assistance Disabled, Medically Needy Disabled, Medically Indigent Child, Medically Indigent Adult, and Refugees.

Emergency Services - Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.

Encounter Data - Reports submitted by Providers/Practitioners, IPA/Medical Groups, and affiliated subcontracted health plans documenting encounters with plan members. Encounter data may also be drawn from MHC or its affiliated subcontracted health plan via aggregate claims data from the Management Information System.

Enrollment Form - See "Medi-Cal Choice Form."

Evidence of Coverage (EOC) - The document provided to plan members describing access, benefits, and exclusions of plan services.

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

Fraud - an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2).

Geographic Managed Care (GMC) - A program which requires Medi-Cal beneficiaries who reside in a designated geographic area to enroll in one of two or more competing health plans under contract with the DHCS.

Healthcare Effectiveness Data and Information Set (HEDIS) - A widely used set of performance measures in the managed care industry developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used for quality improvement activities, health management systems, Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report card for managed care organizations.

Health Care Options (HCO) (formerly Health Choice) - The State Department of Health Care Services' program that provides Medi-Cal beneficiaries with information about healthcare benefits and with enrollment and disenrollment assistance.

Health Insurance Portability and Accountability Act (HIPAA) - The Federal Law that requires all healthcare providers to protect the privacy and security of members protected health information (PHI).

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

Independent Practice Association (IPA) - A legal entity, the members of which are independent Providers/Practitioners who contract with the IPA for the sole purpose of having the IPA contract with one or more HMOs.

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

Management Information System (MIS) - System of organizing and aggregating data so as to enable rapid access to data. Often used to refer to computer systems used to pay claims, maintain Provider/Practitioner databases, and generate reports.

Maximus - The vendor contracted by the Department of Health Care Services that provides Medi-Cal beneficiaries with information about selecting a health plan. Maximus is also responsible for the mailing of enrollment packets to new Medi-Cal beneficiaries.

Medi-Cal Choice Form (A.K.A. Medi-Cal Enrollment Form) - This form is distributed by Health Care Options (HCO) and is used for Medi-Cal Beneficiaries to select their health plan and primary care practitioner. This form may also be used for beneficiaries to disenroll from a health plan.

Medical Group - A medical group practice that holds a contract with a health plan.

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

Medically Necessary - Those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or

other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Plan policy.

Medical Eligibility Data System (MEDS) Tape - The computerized data vehicle (tape) DHCS sends monthly to MHC for member eligibility determination. This tape must be processed by MHC to extract the data regarding eligibility prior to printing updated eligibility rosters and calculating capitation payments.

Member - Any enrolled individual on whose behalf periodic payments are made to MHC and is eligible to receive covered services.

Member Complaint/Grievance - A grievance is any expression of dissatisfaction or complaint by a member or member's designated representative that remains unresolved to the member's satisfaction.

NCQA - National Committee for Quality Assurance.

National Provider Identifier (NPI) - The National Provider Identifier is a 10 digit number assigned by Centers for Medicare & Medicaid Services (CMS) to all covered providers of healthcare who transmit information electronically (HIPAA Transactions). The NPI is intended to improve efficiency and effectiveness of the healthcare system by reducing the number of identifiers associated with providers and facilities (i.e. UPIN, BCBS, Medicaid, other payer specific numbers). As of May 23, 2007 any healthcare provider who transmits health information electronically is required to have an NPI. All HIPAA transactions must use an NPI as the sole means to identify a provider of service. The NPI number last indefinitely and does not change regardless of job or location changes. There are 2 types of NPI: Individual: Physicians, physician assistants, nurse practitioners, chiropractors. Organization: Hospitals, clinics, labs (May have multiple NPIs for each subpart – urgent care, lab, pharmacy, etc.)

Newborn Child - A newborn child is covered for the month of birth and the following month when delivered by the mother during her membership with the Plan.

Plan - Molina Healthcare of California Partner Plan, Inc.

Potential Quality of Care (PQOC) - Process to identify opportunities to evaluate, review, and address a potential quality of care issue.

Practitioner - The professional who provides health care services. Practitioners are required to be licensed as defined by law. A practitioner that participates in MHC's network may be referred to as a "participating or contracted" practitioner.

Preventive Care - Health care designed to prevent disease and/or its consequences. There are three (3) levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after disease has occurred.

Primary Care - A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and/or midlevel practitioners. This type of care emphasizes caring for the member's general health needs as opposed to focusing on specific needs involving the use of specialists.

Primary Care Practitioner (PCP) - Physician that provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. A woman may select an obstetrician/gynecologist as her PCP.

Protected Health Information (PHI) - Under the US Health Insurance Portability and Accountability Act (HIPAA), is any information about health status, provision of health care, or payment for health care that can be linked to an individual; including any part of a patient's medical record or payment history.

Provider - An institution or organization that provides services for the managed care organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term "practitioner" to refer to the professionals who provide health care services. However NCQA recognizes that a "provider directory" generally includes both providers and practitioners, and the inclusive definition is the more common usage of the term "provider." A provider that participates in MHC's network may be referred to as a "participating or contracted" provider.

Provider/Practitioner Grievance or Complaint - That written action which sets into motion the appeal process concerning claims or authorization disputes according to Title 22, sections 53914.5 and 56262 of the California Code of Regulations.

Quality Improvement (QI) - A formal set of activities to assure the quality of clinical and nonclinical services provided as outlined in MHC's Quality Improvement Program. Quality Improvement includes assessment and improvement actions taken to remedy any deficiencies identified through the assessment process. The Providers/Practitioners agree to abide by and participate in MHC's QI Program.

Referral - The practice of sending a patient to another Provider/Practitioner for services or consultation which the referring Provider/Practitioner is not prepared or qualified to provide.

Sensitive Services - The following services are considered sensitive: sexual assault, confidential HIV testing and counseling, drug or alcohol abuse for children of 12 years of age or older, pregnancy, family planning, and sexually transmitted diseases (drug or alcohol abuse and sexually transmitted diseases are designated by the Director of DHCS for children 12 years of age or older).

Service Area - The geographic area that the Plan services as designated and approved by the California Department of Managed Health Care.

Short-Doyle Medi-Cal Mental Health Services (SD/MC) - Program operated by the State Department of Mental Health to provide necessary community mental health services to Medi-Cal beneficiaries that meet Short-Doyle eligibility criteria as defined in Title 22, CCR, Section 51341. Services include crisis intervention, crisis stabilization, inpatient hospital services, crisis residential treatment case management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication, and support services.

Specialist - A physician who is responsible for the specific, specialized health care of a member. A specialist may or may not be board certified.

Utilization Management (UM) - A formal prospective, concurrent, and/or retrospective critical examination of appropriate use of segments of the health care system.

Waste - Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

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