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INTRODUCTION

Welcome
Welcome to California Health & Wellness. We thank you for being part of California Health & Wellness’s network of participating physicians, hospitals and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. California Health & Wellness works to accomplish this goal by partnering with the providers who oversee the healthcare of California Health & Wellness’ members.

About California Health & Wellness
California Health & Wellness is a managed care organization (MCO) contracted with the California Department of Health Care Services (DHCS) to serve the California Medi-Cal and to apply its expertise to work with members to improve their health status and quality of life. California Health & Wellness’s management company, Centene Corporation (“Centene”), has been providing comprehensive managed care services to individuals receiving benefits under government-sponsored healthcare programs for more than 28 years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. Centene also contracts with other healthcare and commercial organizations to provide specialty services. California Health & Wellness is a physician-driven organization that is committed to building collaborative partnerships with providers. California Health & Wellness will serve our members consistent with our core philosophy that quality healthcare is best delivered locally.

Our Mission
California Health & Wellness strives to provide improved health status, successful outcomes, and member and provider satisfaction. California Health & Wellness’s service model has been designed to achieve the following goals:

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

All of our programs, policies and procedures are designed with these goals in mind. We are happy to have you as part of our network and hope that you will assist California Health & Wellness in reaching these goals.

How to Use This Manual
California Health & Wellness is committed to working with our provider community and members to deliver a high level of satisfaction with quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to California Health & Wellness’s operations, benefits and policies and procedures for providers. This Provider Manual will be posted on our website at www.cahealthwellness.com where providers can review and print it free of charge. Providers will be notified of material changes to the Provider Manual via bulletins and notices posted to California Health & Wellness’s secure website and in its weekly Explanation of
Payment notices. For hard copies or CD copies of this Provider Manual, or if you need further explanation on any topics discussed in the provider manual, please contact the Provider Services Department (Provider Services) at 1-877-658-0305.

**KEY CONTACTS AND IMPORTANT PHONE NUMBERS**

The following chart includes several important telephone and fax numbers available to your office. When calling California Health & Wellness, please have the following information available:

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

### Health Plan Information

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<td>1-877-302-3434</td>
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<td>1-877-302-3434</td>
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<td>TDD/TYY 1-866-274-6083</td>
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California Department of Managed Health Care (DMHC) 1-888-466-2219


To report suspected waste, fraud, or abuse to California Health & Wellness 1-866-685-8664


Non-Emergent Transportation www.cahealthwellness.com 1-877-658-0305

Interpreter Services 1-877-658-0305

Ethics and Compliance Hotline 1-800-345-1642

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

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

For assistance with Electronic Claims Submissions
California Health & Wellness c/o Centene EDI Department 1-800-225-2573, ext. 25525 Or by e-mail to: EDIBA@centene.com

PROVIDER RELATIONS DEPARTMENT

The California Health & Wellness Provider Relations Department ("Provider Relations") is dedicated to making each participating provider's experience with California Health & Wellness a positive one. Provider Services and Provider Relations are responsible for oversight, coordination or initiation of the services listed below for all providers:

- Provider credentialing and contracting
- Provider re-credentialing
• Physician and office staff initial and ongoing education, training (California Health & Wellness shall conduct initial training within 10 business days of providers having an active status)
• Hospital, facility and ancillary provider initial and ongoing education and training.
• Distribution of Provider Manuals and similar provider reference materials - The Provider Manual shall be made available no later than seven calendar days after the Provider is included in the network.
• Assistance with claims inquiries and other administrative services
• Assistance with installation, access, and training regarding available web-based tools and functions
• Distribution of notices, bulletins, newsletters and similar information regarding program, process or policy updates or changes
• Secret shopper evaluations
• On-site quality reviews
• Regularly scheduled in-service meetings

The Provider Relations can be reached toll free at 1-877-658-0305, Monday - Friday 8:00 a.m. - 5:00 p.m. Our in-house Provider Relations Specialists work with our Provider Relations Representative to assist providers and their staff. As a participating provider, you and your office staff will have a dedicated Provider Relations Representative who will be a key contact for you and your office staff and who will provide education and training regarding California Health & Wellness’s administrative processes. He/she will visit you or your designated office manager on a routine basis. Regularly scheduled in-service meetings are intended to be a proactive way for us to build a positive relationship with you and your staff; to identify issues, trends or concerns quickly; to answer questions; to share new information regarding the program; and to address any changes within your practice (i.e., change in office staff, new location) or scope of service. The main mission for each Provider Relations Representative is to ensure you and your staff receives stellar service support from California Health & Wellness.

Providers and their office staff are encouraged to call or e-mail their dedicated Provider Relations Representative for assistance at any time. For example, contact your Provider Relations Representative to:

• Report any change to your practice (i.e. practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance status)
• Initiate credentialing of new providers to the practice
• Schedule an in-service training for new staff
• Conduct ongoing education for existing staff
• Obtain clarification of state and health plan policies and procedures and contract language
• Find out about special programs available for members and/or providers
• Request fee schedule information
• Ask questions regarding your Membership list (patient panel)
• Get assistance relating to claims or encounter submissions
• Learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility
Another key responsibility of the Provider Relations Representative is to monitor network adequacy on a continual basis in order to ensure California Health & Wellness is in compliance with the California Department of Health Care Service’s access standards and to ultimately ensure network sufficiency for members that mirrors community access standards. Your dedicated Provider Relations Representative will keep you and your staff apprised of any network changes, new additions or needs within the geographic area you serve, and may - from time to time - survey you regarding your referral network and any preferences you may have with regard to certain providers to target for participation in the California Health & Wellness provider network.

PRODUCT SUMMARY

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

Below is a summary of Categories of Eligibility that will be included in the Medi-Cal program:

- Temporary Assistance for Needy Families (TANF)
- Children’s Health Insurance Program (CHIP)
- Seniors and Persons with Disabilities (SPD)
- Foster Care

VERIFYING ELIGIBILITY

Member Eligibility Verification

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

1. Log on to the secure provider portal at www.cahealthwellness.com. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medi-Cal ID and date of birth. Please note that you must request access to the secure website by visiting the web in order to access information via the secure provider portal.

2. Call our automated member eligibility IVR system. From any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24-hours a day. The automated system will prompt you to enter the member Medi-Cal ID and the month of service to check eligibility.

3. Call California Health & Wellness Provider Services. If you cannot confirm a member’s eligibility using the methods above, call our toll-free number at 1-877-658-0305. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name or member Medi-Cal ID to verify eligibility.
Through California Health & Wellness’s secure provider web portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The patient list is reflective of all changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Children’s Health and Disability Prevention (CHDP) exam. In order to view this list, log on to www.cahealthwellness.com and complete the registration process.

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

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

- The member’s Name
- The member’s Medi-Cal Number
- The effective date
- The PCP’s name and telephone number
- The California Health & Wellness name
- The Member Services 24-hour, seven days a week number: 1-877-658-0305

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

**Member Identification Card**

Whenever possible, in addition to their California Health & Wellness ID card, we recommend providers ask members to present a photo ID card each time non-emergent services are rendered. If you suspect fraud, please contact Provider Services at 1-877-658-0305 immediately.
California Health & Wellness Website

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

California Health & Wellness’s website is located at [www.cahealthwellness.com](http://www.cahealthwellness.com). Providers can find the following information on the public website:

- Provider Manual
- Provider Billing Manual
- Information regarding electronic transactions
- Pre Authorization Needed Tool to determine if a prior authorization is required (by entering a CPT, HCPCs or Revenue code)
- Forms
- California Health & Wellness News
- Clinical Guidelines
- Provider Bulletins
- Provider Newsletters
- Member Handbook
Secure Website

The California Health & Wellness secure provider website enables providers to check member eligibility and benefits, submit and check status of claims, submit claims adjustments, request authorizations, and send messages to communicate with California Health & Wellness staff. California Health & Wellness’s contracted providers and their office staff have the opportunity to register for our secure provider website quickly and easily. We offer tools that make obtaining and sharing information easy! It’s simple and secure! Go to www.cahealthwellness.com to register. On the home page, select the Login link on the top right to start the registration process.

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

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

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

PRIMARY CARE PROVIDERS (PCP)

The primary care provider (PCP) is the cornerstone of California Health & Wellness’s service delivery model. The PCP serves as the “medical home” for the member. The “medical home” concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes. California Health & Wellness offers a robust network of primary care providers to ensure every member has access to a medical home within the required time and travel distance standards:

- Within 10 miles or 30 minutes

California Health & Wellness requests that PCP’s inform our Member Services Department (“Member Services”) when a California Health & Wellness member misses an appointment, so we may monitor and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of emergency room services.

Provider Types That May Serve As PCPs

Health Care professionals who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, nurse practitioners, certified nurse midwives and physician assistants. The PCP may practice in a solo or group setting or at a Federally Qualified Health Center “FQHC,” Rural Health Center “RHC,” Indian Health Center “IHC” or an outpatient clinic. California Health & Wellness may allow some specialists to serve as a member's PCP for members with multiple disabilities or with chronic conditions, as long as the specialist
agrees, in writing, and is willing to perform the responsibilities of a PCP as stipulated in this Provider Manual.

**Member Panel Capacity**

All PCPs may reserve the right to state the number of members they are willing to accept into their panel. California Health & Wellness DOES NOT guarantee that any provider will receive a certain number of members.

The provider to member ratio shall not exceed the following:

- Primary Care Providers – 1: 2,000
- Physicians – 1: 1,200
- Non-Physician Medical Practitioners – 1: 1,000

Physician Supervisor to Non-Physician Medical Practitioner ratio shall not exceed the following:

- Nurse Practitioner 1:4
- Physician Assistants 1:4
- Four Non-Physician Medical Practitioners in any combination that does not include more than three Certified Nurse Midwives or two Physician Assistants

The panel capacity for Federally Qualified Health Centers will be based upon those standards established by the Health Resources and Services Administration.

If a PCP desires a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact California Health & Wellness Provider Services at 1-877-658-0305. A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

Providers shall notify California Health & Wellness in writing at least 45 days in advance of his or her inability to accept additional Medi-Cal covered persons under California Health & Wellness agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. California Health & Wellness prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medi-Cal members.

**Medical Home Model**

California Health & Wellness is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by members of their own care and reduce avoidable costs over time. California Health & Wellness will actively partner with our providers, with community organizations, and groups representing our members to achieve this goal through the meaningful use of health information technology (HIT). California Health & Wellness’s support to primary care providers acting as patient centered medical homes shall include, but is not limited to, the development of systems, processes and information that promotes coordination of the services to the member outside of that provider’s primary care practice.

From an information technology perspective, we offer several Health Information Technology applications for our network providers. Our secure Provider Portal offers tools that will help support providers in the implementing a medical home model of care. These tools include:
- Online Care Gap Notification
- Member Panel Roster including member detail information
- TruCare Service Plan
- Health Record
- Provider Overview Report

**Assignment of Medical Home**

We recognize the importance of nurturing the patient-PCP relationship as the cornerstone of care continuity for members. Indeed many new members will already have existing relationships with network PCPs. California Health & Wellness assures continuance of previous provider relationships with members through its ongoing member outreach efforts that starts when we first receive notification of the member’s enrollment with our plan and when we learn of an existing member-PCP relationship (such as through State claim data, member initiated contact, provider rosters or similar means). Since continuity of care is so critical, our efficient eligibility system establishes that link and generates ID cards noting the PCP. All California Health & Wellness staff members who come in contact with members are trained on the PCP selection process and taught how to assist members who do not yet have an established relationship with a PCP. Our first goal is to ensure every member has a PCP, which we achieve by applying the PCP auto-assign algorithm for members who have not yet selected a PCP. Pregnant members who do not have a PCP will receive a call from a member Service Representative who will facilitate PCP selection within five business days of processing the enrollment file. Member Services Representatives (MSRs) will call all other members who have not selected a PCP and cannot be auto-assigned within 30 calendar days of enrollment to facilitate PCP selection.

**Primary Care Provider (PCP) Responsibilities**

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

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all associated California Health & Wellness members, or entering into an arrangement for management of inpatient hospital admissions of members.
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions.
- Educate members on maintaining healthy lifestyles and preventing serious illness.
- Provide screenings, well care and referrals to community health departments and other agencies in accordance with the DHCS requirements and public health initiatives.
- Based on provider assessment, conduct a behavioral health screen to determine whether the member requires behavioral health services.
- Maintain continuity of each member's healthcare by serving as the member's medical home.
- Offer hours of operation that are no less than the hours of operation offered to commercial and fee for service patients.
• Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide.
• Ensure follow-up and documentation of all referrals including to services available under the State’s fee for service program.
• Collaborate with California Health & Wellness’s case management program as appropriate to include, but not limited to, performing members screening and assessment, development of plan of care to address risks and medical needs, linking the members to other providers or support services (medical, residential, social and community) as needed.
• Maintain a current and complete medical record for the members in a confidential manner, including documentation of all services and referrals provided to the members, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
• Adhere to the CHDP periodicity schedule for members under 21 years of age.
• Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current Pre Authorization Needed Tool on our website, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care.
• Share the results of identification and assessment for any member with special healthcare needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated.
• Actively participate in and cooperate with all California Health & Wellness’s quality initiatives and programs.
• Ensure coordination with community mental health programs, including obtaining consent from members to release information regarding primary care.
• Perform the patient Initial Health Assessment (IHA) including an Individual Health Education Behavioral Assessment (IHEBA) consisting of the patient’s physical examination to assess the Member’s current acute, chronic and preventive health needs for each New Member. IHA for Member’s under the age of eighteen months should be completed within sixty (60) calendar days following the date of enrollment. IHA for Member’s eighteen months and older should be completed within one-hundred (120) calendar days of enrollment.

PCPs may have a formalized relationship with other PCPs to see their members when circumstances (e.g. vacation) dictate. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them, regardless of any additional PCP engagement.

Referrals
It is California Health & Wellness’s preference that the PCP coordinates members’ healthcare services; however, PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of what the PCP can provide. Paper referrals are not required. The PCP must obtain prior authorization from California Health & Wellness for referrals to certain specialty providers as noted on the Pre Authorization Needed Tool on our website. All out-of-network
services require prior authorization. A provider is required to promptly notify California Health & Wellness when a pregnancy is identified or prenatal care is rendered.

In accordance with state law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the providers’ family has a financial relationship.

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

Immunization Program

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

To enroll in the VFC program or receive more information, providers should contact the Department of Health Care Services (DHCS) Immunization Branch by telephone at: 1-877-243-8832, by fax at 1-877-329-9832 or by writing to the following address:

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

California Health & Wellness will reimburse an administration fee per dose to providers who administer the free vaccine to eligible members through the VFC program or other sources. Please refer to the California Health & Wellness Provider Billing Manual for instructions on how to submit claims.

Specialist Responsibilities

California Health & Wellness encourage specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the members’ care and ensure the referred specialty physician is a participating provider within the California Health & Wellness network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following California Health & Wellness’s referral guidelines.

Emergency admissions will require notification to California Health & Wellness’s Medical Management Department within one day of admission to conduct medical necessity review. All non-emergency inpatient admissions require prior authorization from California Health & Wellness’s Medical Management Department.
The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from California Health & Wellness’s Medical Management Department (Medical Management) if needed before providing services
- Coordinate the member’s care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all California Health & Wellness quality initiatives and programs

California Health & Wellness providers should refer to their contract for complete information regarding provider obligations and mode of reimbursement, or contact their Provider Relations Representative with any questions or concerns.

**Mainstreaming**

California Health & Wellness considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a California Health & Wellness member a covered services or availability of a facility
- Providing a California Health & Wellness member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay members (examples: different waiting rooms or appointment times or days)
- Subjecting a California Health & Wellness member to segregation or separate treatment in any manner related to covered services
Appointment Accessibility Standards

California Health & Wellness follows the appointment accessibility requirements as determined by DHCS and DMHC, and applicable regulatory and accrediting agencies. California Health & Wellness monitors compliance with the appointment accessibility standards on at least an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Scheduling Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Urgent Primary care</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
</tr>
<tr>
<td>No Prior Authorization Required</td>
<td>Within 48 Hours of a request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization Required</td>
<td>Within 96 Hours of request</td>
</tr>
<tr>
<td>Emergent</td>
<td>On demand service / 24 hours a day 7 days a week</td>
</tr>
<tr>
<td>Specialist</td>
<td>Within 15 business days of request</td>
</tr>
<tr>
<td>Non Urgent /Ancillary services for diagnosis or treatment of injury, illness or other health condition</td>
<td>Within 15 business days of request</td>
</tr>
<tr>
<td>First Prenatal Visit</td>
<td>Within two weeks of request</td>
</tr>
</tbody>
</table>

**Clinical:** Appointments for members for covered health care services shall be within a time period appropriate for their individual condition.

All providers must offer hours of operation that are no less than the hours of operation offered to commercial and fee for service patients.

**Covering Providers**

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another California Health & Wellness network provider. In the event of unscheduled time off, please notify Provider Relations of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and, if the covering provider is not a California Health & Wellness network provider, he/she will be paid as a non-participating provider.
**Telephone Arrangements**

PCPs and Specialists must:

- Answer the member’s telephone inquiries on a timely basis appropriate for the member’s condition.
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g. wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within
    - 30 minutes
    - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider’s absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member’s medical record
- Provide for a system or service to address calls made after office hours
- During after-hours, a provider must have arrangement for:
  - Access to a covering physician
  - An answering service
  - Triage service or a voice message that provides a second phone number that is answered
  - Any recorded message must be provided in English and Spanish, if the provider’s practice includes a high population of Spanish speaking members

**24-Hour Access**

California Health & Wellness’s PCPs and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, seven days a week.

**Note:** If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to members receiving urgent or emergent care.

California Health & Wellness will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (“QIP”).

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider’s office telephone number is only answered during office hours
- The provider’s office telephone is answered after-hours by a recording that tells patients to leave a message
• The provider’s office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed
• Returning after-hours calls outside thirty minutes

The selected method of 24-hour coverage chosen by the provider must connect the member or caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office’s daytime telephone number.

California Health & Wellness will monitor providers’ offices through scheduled and unscheduled visits conducted by California Health & Wellness’s Provider Relations staff.

Hospital Responsibilities
California Health & Wellness utilizes a network of hospitals to provide services to California Health & Wellness members. Hospital services providers must be qualified to provide services under the California Medi-Cal program. All services must be provided in accordance with applicable state and federal laws and regulations.

Hospitals must:
• Obtain authorizations for all inpatient and selected outpatient services as listed on the current Pre Authorization Needed Tool on our website, except for emergency stabilization services
• Notify California Health & Wellness’s Medical Management Department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member’s name, Medi-Cal ID, presenting symptoms/diagnosis, DOS and member’s phone number.
• Notify California Health & Wellness’s Medical Management Department of all admissions within one business day
• Notify California Health & Wellness’s Medical Management Department of all newborn deliveries within one business day of the delivery

Marketing Requirements
All marketing materials utilized by California Health & Wellness must be approved by DHCS and DMHC prior to distribution to members. Additionally:
• Neither California Health & Wellness nor its contracted providers will offer anything of value as an inducement to enrollment including the sale of other insurance to attempt to influence enrollment.
• Neither California Health & Wellness nor its contracted providers will directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment or for any other purpose.
• California Health & Wellness or its contracted providers may not make any written or oral statements in marketing materials that a potential member must enroll with California Health & Wellness in order to obtain benefits or not retain existing benefits.
• California Health & Wellness may not make any assertion or statement in marketing materials that California Health & Wellness is endorsed by CMS, the Federal or State government or similar entity.
• California Health & Wellness providers should not create and distribute any marketing materials to California Health & Wellness members without prior approval by California Health & Wellness, DHCS and DMHC. Should you have any questions regarding these marketing requirements, please feel free to contact Provider Services or your Provider Relations Representative.

Advance Directives
California Health & Wellness is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. California Health & Wellness is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to California Health & Wellness members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

California Health & Wellness recommends to its PCPs and physicians that:
• The first point of contact for the member in the PCP’s office should ask if the member has executed an advance directive and the member’s response should be documented in the medical record.
• If the member has executed an advance directive, the first point of contact should ask the Member to bring a copy of the advance directive to the PCP’s office and document this request in the member’s medical record.
• An advance directive should be included as a part of the member’s medical record and include mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. If possible, a copy of the advance directive should be collected and placed in members’ chart. Any such discussion should be documented in the medical record.

Interpreter Services
California Health & Wellness will make oral interpretation services available free of charge for each member or potential member. Members shall not be charged for interpretation services. Contact Member or Provider Services at 1-877-658-0305 for assistance.

Voluntarily Leaving the Network
Providers must give California Health & Wellness notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the
member’s new provider upon request and facilitate the member’s transfer of care at no charge to California Health & Wellness or the member.

California Health & Wellness will notify affected members in writing of a provider termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. If the terminating provider is a PCP, California Health & Wellness will request that the member elect a new PCP within 15 business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, California Health & Wellness will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until California Health & Wellness can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, California Health & Wellness will reimburse the provider for the provision of covered services for a period of up to 90 days from the provider’s termination date. In addition, California Health & Wellness will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery. Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from California Health & Wellness

California Health & Wellness will provide written notice to a member within seven days, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

**CULTURAL COMPETENCY**

Cultural Competence is the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels of an organization, (i.e., policy, governance, administrative, workforce, provider, and consumer/client). Cultural Competence is developmental, community focused, and family oriented. In particular, it is the promotion of quality services to the underserved, of all cultures, races, ethnic backgrounds, and religions through the valuing of differences and integration of cultural attitudes, beliefs, and practices into diagnostic and treatment methods, and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Cultural Competence activities include the development of skills through training, use of self-assessment for providers and systems, and implementation of objectives to ensure that governance,
administrative policies and practices, and clinical skills and practices are responsive to the culture and diversity within the populations served. It is a process of continuous quality improvement.

California Health & Wellness is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of its credentialing proves, California Health & Wellness will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider’s in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Network providers must ensure that Members understand they have access to the following cultural and linguistic services without cost to them:
  - Oral interpretation in all languages at all key points of contact;
  - Print, multimedia materials and signage in Spanish, in the preferred format (e.g. Braille, large print, audio, CD), and in additional languages and formats upon request;
  - Resources to facilitate access and communication for members with disabilities (e.g. augmentative & alternative communication devices, auxiliary aids & services, telephone & video relay systems, etc);
  - Information on treatment options and alternatives in a manner that is respectful of, and takes into account, diverse cultural beliefs and health literacy; and
  - Referrals to community based organizations and individuals who are trusted members of the community and can serve as cultural brokers.

- Medical care is provided with consideration of the members’ race/ethnicity and language and its impact/influence on the members’ health or illness

- Office staff that routinely interact with members have access to and participate in cultural competency training and development

- Office staff that is responsible for data collection and makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children

- Treatment plans are developed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member’s perspective on healthcare.

- Office sites have posted and printed materials in English and Spanish, and as required by California Department of Health Care Services, any other required non-English language.

- Family and Friends should not be used to provide interpretation services except on request from the member. Children shall never serve as an interpreter.
BENEFIT EXPLANATION AND LIMITATIONS

California Health & Wellness Benefits

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

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

**Medical Services**

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Details and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Covered</td>
<td>Refer to Medi-Cal for limits here: Use this link: <a href="#">Acupuncture</a> and then scroll down and then click on the link for “Acupuncture Services”.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>For more information, use these links: <a href="#">www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx</a> County Mental Health departments contact list: <a href="#">www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx</a> Substance Use Disorder Services: <a href="#">www.dhcs.ca.gov/provgovpart/Pages/SUD-ProvPartners.aspx</a></td>
</tr>
<tr>
<td>Alcohol and Substance Abuse Treatment Services</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td></td>
</tr>
<tr>
<td>Allergy Services (testing and desensitization)</td>
<td>Covered</td>
<td>Limits applicable when office visits billed in conjunction with allergy services</td>
</tr>
<tr>
<td>Ambulance – Emergency Transportation</td>
<td>Covered</td>
<td>Ground, Rotary Wing, Fixed Wing</td>
</tr>
<tr>
<td>Ambulance – Non-Emergency Transportation</td>
<td>Covered</td>
<td>Ground, Rotary Wing, Fixed Wing</td>
</tr>
<tr>
<td>Ambulatory Surgery Center - ASC</td>
<td>Covered</td>
<td>Must be billed on UB – 04 (or successor form). ASC billed on a CMS (HCFA) will deny as not billed on appropriate form.</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Details</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>
| **Audiology Services**                       | Covered           | Members age 21 and older are subject to the state’s Optional Benefits Exclusion (OBE) coverage guidelines.  
Under age 21 refer to California Children’s Services (CCS) guidelines - use this link: Hearing_Audiology, and then scroll down and click on the link for “Audiological Services.” |
| **Bariatric Surgery**                        | Covered           | Only covered in a Centers for Medicare & Medicaid Services Certified Center of Excellence Other limitations may apply |
| **Behavioral Health Treatment for Autism Spectrum Disorder** | Covered           | You do not qualify for BHT services if you:  
- Are not medically stable; or  
- Need 24-hour medical or nursing services; or  
- Have an intellectual disability (ICF/ID) and need procedures done in a hospital or an intermediate care facility.  
If you are currently receiving BHT services through a Regional Center, the Regional Center will continue to provide these services until a plan for transition is developed. Further information will be available at that time.  
You can call California Health & Wellness if you have any questions or ask your Primary Care Provider for screening, diagnosis and treatment of ASD. |
| Biofeedback                                  | Not Covered       |                                                                         |
| Birthing Centers                             | Covered           | Limitations may apply                                                   |
| Blood and Blood Derivative Products          | Covered           | Designated providers for contract blood factors Other limitations may apply |
| Blood Pressure Equipment                     | Covered           | Covered only for documented malignant hypertension or End Stage Renal Disease |
| Bone Density Testing                         | Covered           | One test per year for specified diagnoses  
Not covered if for screening purposes only |
<p>| Breast Pumps                                 | Covered           |                                                                         |
| California Children’s Services (CCS) Program medical services for | Covered by California Children’s Service Program | For more information about CCS: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx</a>; or use this link to get contact for the |</p>
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with certain special health problems</td>
<td></td>
<td>DHCS Children’s Medical Services: CMS_Contacts. Only for members under age 21</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Covered</td>
<td>Member and trial must meet specific medical criteria</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered</td>
<td>Under age 21 refer to CCS guidelines here: Use this link: General_Medicine, and then scroll down and click on the link for “Chemotherapy: An Overview”. Also use this link to get contact information for the DHCS Children’s Medical Services: CMS_Contacts</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Covered by Medi-Cal Fee-For-Service when provided by FQHC or RHC</td>
<td>Refer to Medi-Cal for limits here: Use this link: Chiropractic, and then scroll down and click on the link for “Chiropractic Services”. Also use this link to get contact information for the DHCS Children’s Medical Services: CMS_Contacts</td>
</tr>
<tr>
<td>Child Health and Disability Prevention (CHDP) Services</td>
<td>Covered</td>
<td>Ages 0 through their 20th year and 11 months</td>
</tr>
<tr>
<td>Christian Science Practitioners</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Contact the Medi-Cal FFS Program for more information: <a href="http://www.medi-cal.ca.gov/contact.asp">http://www.medi-cal.ca.gov/contact.asp</a></td>
</tr>
<tr>
<td>Circumcision</td>
<td></td>
<td>Not covered if Routine / Elective: Covered if Medically Necessary - may require prior authorization</td>
</tr>
<tr>
<td>Community Based Adult Services (CBAS)</td>
<td>Covered</td>
<td>Limitations apply</td>
</tr>
<tr>
<td>Comprehensive Perinatal Services Program</td>
<td>Covered</td>
<td>Limitations may apply</td>
</tr>
<tr>
<td>Cosmetic Surgery (not medically necessary)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Dental (dental providers / services)</td>
<td>Covered by Denti-Cal</td>
<td>Use this link for more information on Denti-Cal for limits: Denti-Cal</td>
</tr>
<tr>
<td>Dental (medical providers / medical services related to dental services)</td>
<td>Covered</td>
<td>Certain prescription drugs Laboratory services Pre-admission physical examinations Facility fees / anesthesia both inpatient / outpatient</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>Covered</td>
<td>Under age 21 refer to CCS guidelines here: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx</a>; or use this link to get contact for the DHCS Children’s Medical Services: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">CMS Contacts</a></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered</td>
<td>Under age 21 refer to CCS guidelines here: Use this link: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">Chronic Dialysis</a></td>
</tr>
</tbody>
</table>
| Directly Observed Therapy (DOT)              | Covered by Medi-Cal fee-for-service and County Health Department | DOT is specific TB (tuberculosis) treatment rendered by Local Health Departments  
Refer to Medi-Cal for limits here: Use this link: [General Medicine](http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx), and then scroll down and click on the link for “Tuberculosis” |
| Durable Medical Equipment                    | Covered    |                                                                                                                                        |
| Early and Periodic Screening, Diagnosis and Treatment (EPSDT) | Covered    | Only for Members under age 21 years                                                                                                                                                           |
| Emergency Room Services                      | Covered    |                                                                                                                                        |
| Enteral and Parenteral Nutrition             | Covered    |                                                                                                                                        |
| Erectile Dysfunction Drugs and Therapies     | Not Covered |                                                                                                                                        |
| Experimental Services (other than those provided in covered clinical trials) | Not Covered | This includes, but is not limited to drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans |
| Family Planning Services (and supplies)      | Covered    | Limitations may apply                                                                                                                                                                         |
| FQHC – Federally Qualified Health Center services | Covered    |                                                                                                                                       |
| Fluoride Varnish (non-dental provider)       | Covered    | Only for members under age 6  
Covered 3 times in a 12 month period  
Service must be provided by physicians, nurses, and other medical personnel |
<table>
<thead>
<tr>
<th>Service</th>
<th>Covered Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Reassignment Surgery</td>
<td>Covered</td>
<td>Procedures that are not medically necessary are not covered Members age 18 &amp; over</td>
</tr>
<tr>
<td>Health Education</td>
<td>Covered</td>
<td>Limitations may apply</td>
</tr>
<tr>
<td>Hearing Aids and Repairs</td>
<td>Covered</td>
<td>Under age 21 refer to CCS guidelines here: Use this link: Hearing Audiology, and then scroll down and click on the link for “Hearing Aids”.</td>
</tr>
<tr>
<td>Hearing Screenings</td>
<td>Covered</td>
<td>Members age 21 and older are subject to the state’s Optional Benefits Exclusion (OBE) coverage guidelines Other limitations may apply</td>
</tr>
<tr>
<td>HIV Testing and Counseling</td>
<td>Covered</td>
<td>Refer to Medi-Cal for limits here: <a href="http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx">http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx</a>, and HCBS</td>
</tr>
<tr>
<td>Home and Community Based Services (HCBS) – Waiver Programs</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td></td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>Covered</td>
<td>Limitations may apply</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered</td>
<td>Limitations may apply</td>
</tr>
<tr>
<td>Hospital Services – Inpatient</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Hospital Services – Outpatient</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy - HBO</td>
<td>Covered</td>
<td>Limitations may apply, depending on diagnosis, frequency, and provider type Under age 21 refer to CCS guidelines here: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx</a>; or use this link to get contact for the DHCS Children’s Medical Services: CMS_Contacts.</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Covered</td>
<td>Not covered if performed only to make a member permanently sterile</td>
</tr>
<tr>
<td>Immunizations (adults and children)</td>
<td>Covered</td>
<td>Vaccines For Children program only for children Other limitations may apply</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Incontinence Creams and Washes</td>
<td>Covered</td>
<td>Members age 21 and older are subject to the state’s Optional Benefits Exclusion (OBE) coverage guidelines Other limitations may apply</td>
</tr>
<tr>
<td>Indian Health Programs</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Infertility (diagnosis and treatment)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Injectable Medications</td>
<td>Covered</td>
<td>Limits apply to certain medications</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Investigational Services</td>
<td>Covered</td>
<td>Including, but not limited to drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but: Testing is not complete, and, The efficacy and safety of such services in human subjects are not yet established, and, The service is not in wide usage Other limitations may apply</td>
</tr>
<tr>
<td>Laboratory and Pathology Services (inpatient and outpatient)</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services - State Serum Alpha-fetoprotein Testing Program</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Administered by the Genetic Disease Branch of California Department of Public Health</td>
</tr>
<tr>
<td>Local Educational Agency (LEA) Services</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Refer to Medi-Cal for limits here: Use this link: <a href="#">LEA Manual</a></td>
</tr>
<tr>
<td>Local Health Department</td>
<td>Covered</td>
<td>Directly Observed Therapy (DOT) is covered by Medi-Cal Fee-For-Service</td>
</tr>
<tr>
<td>Long Term Care (LTC)</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Upon acceptance by state for LTC, member is dis-enrolled from California Health &amp; Wellness Plan Long-term care (LTC) is care in a facility for longer than the month of admission plus one month. These health care facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities Refer to Medi-Cal for limits here: <a href="#">LTC</a> Please note: Hospice services are not considered LTC.</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Information</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mammography (screening)</td>
<td>Covered</td>
<td>Requires prior authorization for women under age 40 and over age 74. Prior authorization is not required for women age 40 – 74.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Covered by California Health &amp; Wellness</td>
<td>Certain Outpatient Mental Health Services for treatment of mild to moderate mental health conditions are covered. Services for relational problems are not covered. Contact Medi-Cal Fee-for-Service Program for information.</td>
</tr>
<tr>
<td></td>
<td>Covered by Medi-Cal Fee-For-Service (with exceptions*)</td>
<td>*Exceptions covered by California Health &amp; Wellness Plan include certain Outpatient Mental Health Services, lab, radiology, pharmacy, Medicare/Medi-Cal crossover claims, FQHC, RHC, IHS, and out of state providers (not border states). Specific diagnoses applicable to Inpatient Hospital and Home Health.</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation (NEMT) – other than ambulance</td>
<td>Covered</td>
<td>Benefit managed by LogistiCare <a href="http://www.logisticare.com">www.logisticare.com</a> Limitations may apply</td>
</tr>
<tr>
<td>Non-Medical Equipment</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Obstetrical/Gynecological Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Oxygen and Respiratory Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>Covered</td>
<td>Limits include, but are not restricted to, specific diagnoses</td>
</tr>
<tr>
<td>Pap Smears (routine/preventative)</td>
<td>Covered</td>
<td>Age 21 &amp; older with limitations For more details, see: <a href="http://www.uspreventiveservicestaskforce.org/uspstf/recomm/recom.htm">USPSTF Recommendations</a></td>
</tr>
<tr>
<td>Pediatric Day Health Care</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Refer to Medi-Cal for limits here: Use this link: <a href="http://www.hcbs.ca.gov/">HCBS</a> then scroll down and click on the “Pediatric Day Health Care” link.</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>For information about In-Home Supportive Services, see: <a href="http://www.cdss.ca.gov/agedblinddisabled/ptg1296.htm">http://www.cdss.ca.gov/agedblinddisabled/ptg1296.htm</a>; for information about home and community-based alternatives, also see: <a href="http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx">http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx</a></td>
</tr>
<tr>
<td>Personal comfort items</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Covered/Not Covered</td>
<td>Details</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered</td>
<td>Speech Therapy: only Members age 21 and older are subject to the state’s Optional Benefits Exclusion (OBE) coverage guidelines. Other limitations may apply. Under age 21 refer to CCS guidelines here: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/MT.aspx">http://www.dhcs.ca.gov/services/ccs/Pages/MT.aspx</a></td>
</tr>
<tr>
<td>Physician, Registered Nurse Practitioner, or Physician Assistant Services</td>
<td>Covered</td>
<td>Members age 21 and older are subject to the state’s coverage guidelines when provided in FQHC or RHC. Other limitations may apply.</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Covered</td>
<td>Contact the Medi-Cal FFS Program for more information: <a href="http://www.medicalexchange.ca.gov/contact.asp">http://www.medicalexchange.ca.gov/contact.asp</a></td>
</tr>
<tr>
<td>Prayer or Spiritual Healing</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Benefit managed by U.S. Script <a href="http://www.uuscript.com">www.uuscript.com</a></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered</td>
<td>Services for children and adults include, but are not limited to; preventative health assessment visits, well child care, screenings (e.g.: pap smears, mammograms, total serum cholesterol, etc.), and immunizations. Some limitations may apply. For further details, see: <a href="http://www.usps">USPSTF_PCRec</a></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>Covered</td>
<td>Some limits apply. Under age 21 refer to CCS guidelines here: Use this link: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">Orthotics_Prosthetics</a> and then scroll down and click on the link for “Orthotic and Prosthetic Appliances”.</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices and specialized footwear</td>
<td>Covered</td>
<td>Benefit managed by NIA <a href="http://www.radmd.com">www.radmd.com</a></td>
</tr>
<tr>
<td>Radial Keratotomy</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered</td>
<td>Under age 21 refer to CCS guidelines here: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx</a>; or contact the DHCS Children's Medical Services for more information: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">CMS_Contacts</a></td>
</tr>
<tr>
<td>Radiology Services (high tech imaging)</td>
<td>Covered</td>
<td>MRI, MRA, CAT and PET. Benefit managed by NIA <a href="http://www.radmd.com">www.radmd.com</a></td>
</tr>
<tr>
<td>Service Description</td>
<td>Coverage</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Radiology Services (other than high tech imaging)</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Surgery (non-cosmetic)</td>
<td>Covered</td>
<td>Some limits apply. Under age 21 refer to CCS guidelines here: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx">http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx</a>; see item M.</td>
</tr>
<tr>
<td>Rehabilitative Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Services not allowed by federal or state law</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Diseases (STD) – screening and treatment</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Specialist Physician Consultations</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Sterilization Services</td>
<td>Covered</td>
<td>Only for members age 21 &amp; older. Consent form is required with claim submission (some exceptions may apply)</td>
</tr>
<tr>
<td>Substance Use Disorder Preventive Services</td>
<td>Covered</td>
<td>Members age 18 years and older can get one (1) expanded screening and three (3) 15-minute brief intervention sessions to address risky alcohol use per year</td>
</tr>
<tr>
<td>Targeted Case Management Services</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Refer to Medi-Cal for limits here: <a href="http://www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx">http://www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx</a></td>
</tr>
<tr>
<td>Temporomandibular Joint Disorder (TMJ) – Medical Treatment</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Covered</td>
<td>Some limitations apply.</td>
</tr>
<tr>
<td>Transplant Services - Kidney</td>
<td>Covered</td>
<td>Under age 21 refer to CCS guidelines here: Use this link: <a href="#">General Medicine</a> and then scroll down and click on the link for “Transplants”.</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transplant Services – Other Major Organs</td>
<td>Covered by Medi-Cal Fee-For-Service</td>
<td>Upon acceptance by approved transplant program member is dis-enrolled from California Health &amp; Wellness Under age 21 refer to CCS guidelines here: Use this link: <a href="#">General Medicine</a> and then scroll down and click on the link for “Transplants”.</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Vision - Other than Optical Lenses</td>
<td>Covered</td>
<td>Benefit managed by OptiCare <a href="#">www.opticare.com</a> Some limitations apply</td>
</tr>
<tr>
<td>Vision – Optical Lenses</td>
<td>Covered</td>
<td>Benefit managed by OptiCare <a href="#">www.opticare.com</a> Some limitations may apply</td>
</tr>
</tbody>
</table>

**Non-Emergent Medical Transportation**

California Health & Wellness will arrange for the non-emergent transportation of members for medically necessary services requested by the member or someone on behalf of the member. California Health & Wellness will require the transportation provider to schedule transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; and not be picked up prior to completion of treatment. California Health & Wellness requests its participating providers, including its transportation vendor, to inform our member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

**Network Development and Maintenance**

California Health & Wellness will ensure the provision of covered services as specified by DHCS and DMHC. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the California Department of Health Care Services and Department of Managed Health Care network adequacy requirements for the Managed Care Organization networks. California Health & Wellness will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with DHCS and DMHC access and availability requirements.
California Health & Wellness offers a network of PCPs to ensure every member has access to a medical home within the required travel distance standards. Practitioners who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistant and advanced registered nurse practitioners.

In addition, California Health & Wellness will have available, at a minimum, the following specialists for members on at least a referral basis:

- Allergy
- Dermatology
- Family Medicine
- Internal Medicine
- General practice
- Cardiology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Pulmonary Disease
- Rheumatology
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Optometry
- Orthopedics
- Otolaryngology
- Pediatric (General)
- Pediatric (Subspecialties)
- Cardiology
- Hematology/Oncology
- Physical Medicine and Rehabilitation
- Podiatry
- Surgery (General)
- Urology
- Vision Care/Primary Eye Care

In the event California Health & Wellness’s network is unable to provide medically necessary services required under the contract, California Health & Wellness shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a California Health & Wellness member, please contact our Medical Management team at 1-877-658-0305 and we will identify a provider to make the necessary referral.
Tertiary Care
California Health & Wellness offers a network of tertiary care inclusive of level one and level two trauma centers, Neonatal intensive care units, perinatology services, comprehensive cancer services, comprehensive cardiac services and pediatric sub specialists available 24-hours per day. In the event California Health & Wellness network is unable to provide the necessary tertiary care services required, California Health & Wellness shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

MEDICAL MANAGEMENT

Overview
California Health & Wellness’s Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m. (excluding holidays). After normal business hours, its NurseWise staff is available to answer questions about prior authorization. Medical Management services include the areas of utilization management, case management, disease management, and quality review. The department clinical services are overseen by the California Health & Wellness medical director (“Medical Director”). The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact:

Medical Management
Phone: 1-877-658-0305
www.cahealthwellness.com

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

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

Our program goals include:

- Guard against over- or under- utilization by monitoring utilization patterns.
- Develop and distribute clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identify and provide case and/or disease management for members at risk for significant health expenses or ongoing care.
- Develop an infrastructure to ensure that all California Health & Wellness members establish relationships with their PCPs to obtain preventive care.
- Implement programs that encourage preventive services and chronic condition self-management.
- Identify members who may be eligible for other programs such as CCS.
- Create partnerships with members/providers to enhance cooperation and support for UMP goals.

Referrals – As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for California Health & Wellness members. PCPs can refer a member to an in network specialist when care is needed that is beyond the scope of the PCP’s training or practice parameters; however, paper referrals are not required. Referrals can be sent to a non-contracted/out of network provider in the event the appropriate specialist needed for the member’s condition is not an in network specialist. Out of network providers and services should obtain a prior authorization. To better coordinate a member’s healthcare, California Health & Wellness encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

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

Notifications - A provider is required to promptly notify California Health & Wellness when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations - Some services require prior authorization from California Health & Wellness in order for reimbursement to be issued to the provider. To verify whether a prior authorization is necessary or to obtain a prior authorization, call or visit our website:

California Health & Wellness
Phone: 1-877-658-0305
www.cahealthwellness.com

Prior Authorization requests may be submitted electronically through the secure Provider Portal.
For more information on conducting these transactions electronically contact:

California Health & Wellness
c/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at: EDIBA@centene.com

Note: If you are part of an Independent Practice Association (IPA), please work with them on the prior authorization process.
Self-Referrals
The following services do not require prior authorization or referral from your doctor:

- Emergency services including emergency ambulance transportation
- Certain Preventive services
- Basic prenatal care
- Treatment or Diagnosis of sexually transmitted diseases services
- HIV testing
- Well Women’s health services Family planning services and supplies from a qualified Medi-Cal family planning provider
- Covered optometric services with a participating provider

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

Prior Authorization and Notifications
Prior authorization is a request to the California Health & Wellness Utilization Management (UM) department for approval of services on the Pre Authorization Needed Tool on our website before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. **Routine prior authorization should be requested at least five calendar days before the scheduled service delivery date or as soon as need for service is identified.** Services that require authorization by California Health & Wellness are listed in the Benefits and Services requiring Authorization Table as provided in this Provider Manual. The PCP should contact the UM Department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization and will require California Health & Wellness Medical Director review and approval. Below is a Table reflecting those services that require prior authorization. **This list is not all-inclusive.** Please visit [www.cahealthwellness.com](http://www.cahealthwellness.com) and use the Pre Authorization Needed Tool or contact the prior authorization department for assistance.

**Note:** If you are submitting authorizations by fax, please only enter the first nine digits of the Medi-Cal identification number.

**Note:** If you are part of an Independent Practice Association (IPA), please work with them on the prior authorization process.
**Prior Authorization as of January 2015**


<table>
<thead>
<tr>
<th>Service</th>
<th>PA - California</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services other than well visits, preventive services, immunizations, emergency services, urgent care services, minor consent services (sexual assault, pregnancy care, family planning, sexually transmitted disease services), HIV testing, abortion</td>
<td>X - for members under the age of 21 years</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td></td>
</tr>
<tr>
<td>DME - including but not limited to: medical supplies, wound v县城, customized equipment</td>
<td>X - certain procedure codes; call or go to CHWP website to determine if authorization is required</td>
</tr>
<tr>
<td>All inpatient hospitalizations (notification at least 5 business days prior to the scheduled date of admit)</td>
<td></td>
</tr>
<tr>
<td>Emergency Admissions and/or Observation Stay (notification within 1 business day of admission)</td>
<td></td>
</tr>
<tr>
<td>Enteral or Parenteral Nutrition Products</td>
<td></td>
</tr>
<tr>
<td>Experimental or investigational treatments/services; clinical trials</td>
<td></td>
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<tr>
<td>General anesthesia for dental services</td>
<td></td>
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<tr>
<td>Hearing Aid Devices/Cochlear Implants</td>
<td></td>
</tr>
<tr>
<td>Radiology Imaging CT, MRA, MRI, PET</td>
<td><a href="http://www.radmd.com">www.radmd.com</a></td>
</tr>
<tr>
<td>Home Health Services including nursing and supplies</td>
<td></td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Implantable devices</td>
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<tr>
<td>Laboratory Services: Genetic /Molecular Diagnostic Testing</td>
<td></td>
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<tr>
<td>Quantitative Drug Screening</td>
<td></td>
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<tr>
<td>Nursing Facility Admissions (Skilled Nursing Facility)</td>
<td></td>
</tr>
<tr>
<td>NICU</td>
<td></td>
</tr>
<tr>
<td>Out of Network Providers and Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient - surgeries and procedures performed in outpatient facilities or ambulatory surgery centers</td>
<td>X - certain procedure codes; call or go to CHWP website to determine if authorization is required</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation - Inpatient</td>
<td></td>
</tr>
</tbody>
</table>
Emergency room and post stabilization services never require prior authorization. Providers should notify California Health & Wellness of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. Providers should notify California Health & Wellness of emergent inpatient admissions within one business day of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

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

**Pharmacy Prior Authorizations**

Some medications listed on the California Health & Wellness Preferred Drug List (PDL) may require a Prior Authorization (PA) or other restrictions listed. These medications will have a PA after them on the PDL for identification. A completed state mandated medication PA form should be faxed to US Script at 1-866-399-0929. The prior authorization fax form is located on the California Health & Wellness website at [www.cahealthwellness.com](http://www.cahealthwellness.com).

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

1. There is a medical reason the member needs the specific medication.
2. Depending on the medication, other medications on the PDL have not worked.
3. The requested medication is not a benefit exclusion or carved-out to Medi-Cal Fee-For-Service.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the California Health & Wellness P&T Committee. Once approved, US Script notifies the prescriber by fax. If the clinical information provided does not meet the coverage criteria for the requested medication, California Health & Wellness will notify the member and the prescribing provider of the denial reason and provide information regarding the appeal process.
Authorization Determination Timelines

California Health & Wellness decisions are made as expeditiously as the member’s health condition requires. For standard service authorizations the decision and notification will be made within five business days from the plan’s receipt of the information reasonably necessary and requested by the plan to make the determination. This timeframe will not exceed 14 calendar days from receipt of the request (unless an extension is requested). “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information within 48 hours of the request can result in an administrative denial of the requested service. For urgent/expedited pre-service requests, a decision and notification is made within 72 hours of the receipt of the request. For urgent concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care decisions are made within 24 hours of receipt of the request. Decisions shall be communicated to the requesting provider within 24 hours of the decision.

Other Medi-Cal Services

The following are covered Fee-For-Service programs under Medi-Cal. These programs are not administered by California Health & Wellness. Please see below descriptions for further information.

- **California Children Services (CCS)** covers eligible services for members under 21 years old. These services are condition specific. CCS services are not covered under the Plan. These services must be rendered by CCS paneled providers and/or facilities. To learn about CCS, become a CCS provider, refer a member to CCS, check eligibility or view a county contact list, please visit [www.dhcs.ca.gov/services/ccs/Pages/default.aspx](http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx).

- **Dental Services** are covered under Fee-For-Service Medi-Cal. Providers may call Denti-Cal toll-free at (800) 423-0507. Members may call the beneficiary Telephone Service Center at (800) 322-6384. Please visit [www.denti-cal.ca.gov/WSI/Default.jsp?fname=Default](http://www.denti-cal.ca.gov/WSI/Default.jsp?fname=Default).

- **HIV/ AIDS Waiver** provides home and community-based services (HCBS) to Medi-Cal beneficiaries with mid-to-late stage HIV / AIDS disease as an alternative to nursing facility or hospital care. To refer a member or learn more, please visit their web at: [www.dhcs.ca.gov/services/medi-cal/Pages/AIDSMedi-CalWaiver.aspx](http://www.dhcs.ca.gov/services/medi-cal/Pages/AIDSMedi-CalWaiver.aspx).

- **Local Education Agency (LEA)** assessment and services are covered under Fee-For-Service Medi-Cal. Please visit [www.dhcs.ca.gov/provgovpart/pages/lea.aspx](http://www.dhcs.ca.gov/provgovpart/pages/lea.aspx).
• **Mental Health and Substance Abuse Services** Mental health services within the mild to moderate range including services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors are covered benefits through the health plan. Other specialty mental health services, alcohol and substance abuse treatment services as well as outpatient heroin detoxification are covered under Fee-For-Service Medi-Cal. Please visit the web at:

www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx

County Mental Health departments contact list:
www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx

Substance Use Disorder Services:
www.dhcs.ca.gov/provgovpart/Pages/SUD-ProvPartners.aspx

• **Regional Centers** provide services for the developmentally disabled, whose disability begins before the member's 18th birthday, is expected to continue indefinitely and presents a substantial disability. The regional center will determine program eligibility based on diagnosis and assessment performed by their office. There are 21 regional centers with more than 40 offices located throughout the state. To refer a member for eligibility determination, questions or additional information, please visit their website at:

www.dds.ca.gov/RC/RCSvs.cfm

**Second Opinion**
California Health & Wellness will reimburse for a second opinion from a qualified health professional within the provider network or arrange for the member to obtain a second opinion outside the network. Members do have a right to seek and cannot be denied a second opinion. Medical Management may be contacted to assist in the coordination of second opinions.

**Assistant Surgeon**
Reimbursement for an assistant surgeon’s service is based on the medical necessity of the procedure itself and the assistant surgeon’s presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

**Clinical Information**
Authorization requests may be submitted by phone or secure web portal Authorization determinations may be communicated to the provider via phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a California Health & Wellness nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.
California Health & Wellness clinical staff requests the minimum clinical information necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Health & Wellness is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

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

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

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

**Clinical Decisions**

California Health & Wellness affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. In addition, it will involve referral of members to other programs providing coverage of specific conditions. California Health & Wellness does not reward practitioners or other individuals for issuing denials of service or care.

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

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the California Health & Wellness Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member’s plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

**Medical Necessity**

“Medical Necessity” means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in Title 22 CCR Sections 51340 and 51340.1, relating to Children’s Health and Disability Prevention (CHDP) Services.

**Review Criteria**

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

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-877-658-0305. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling our toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

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

California Health & Wellness
Appeals Department
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833
Phone: 1-877-658-0305
Fax: 1-855-556-7908

**New Technology**

California Health & Wellness evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the California Health & Wellness population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.
If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management Department at 1-877-658-0305.

**Notification of Pregnancy**

Members that become pregnant while covered by California Health & Wellness may remain a California Health & Wellness member during their pregnancy. The managing or identifying Physician, Certified Nurse Midwife, or Certified Nurse should notify the California Health & Wellness prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visitor confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® program and our High Risk Pregnancy program for women with a history of early delivery.

**Concurrent Review and Discharge Planning**

Nurse Case Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital’s utilization and discharge planning departments and when necessary, with the member's attending physician. The case manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify California Health & Wellness within two business days of delivery with complete information regarding the delivery status and condition of the newborn.

**Retrospective Review**

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to California Health & Wellness was not obtained due to extenuating circumstances. Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of the request.

**California Children’s Services CCS**

Plan members will be eligible to enroll in (or continue enrollment in) California Children’s Services (CCS). This will include children from birth up to 21 years of age with CCS-eligible medical conditions. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions (such as hemophilia, cerebral palsy, heart disease, cancer, infectious diseases producing major sequelae). The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS).

As the PCP, you will still refer the child to CCS if you have sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition.

California Health & Wellness will coordinate with the member, PCP, and CCS to ensure proper classification of charges. CCS will pay for services associated with the eligible diagnosis.
Health & Wellness will not pay for services that are covered by CCS. CCS will only reimburse services by CCS-paneled providers and CCS-approved hospitals within the network; and only from the date of referral.

California Health & Wellness shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between the PCP, the CCS specialty providers, and the local CCS program.

Additional information about the CCS Program is available at:  
www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx

RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

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

Prior authorization is required for the following outpatient radiology procedures:

- CT / CTA
- MRI / MRA
- PET Scan

KEY PROVISIONS:

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

Please call 1-877-658-0305 and follow the prompt for radiology authorizations. California Health & Wellness also provides a link to an interactive website which may be used to obtain on-line authorizations. Please visit www.cahealthwellness.com for more information or call our Provider Services Department.

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM

The California Department of Health Services (DHCS) is Medi-Cal’s comprehensive and preventive child health program for individuals under the age of 21 (ages 0 through their 20th year and 11 months) to receive periodic health screening exams required by Federal Medicaid Early and Periodic Screening mandates in California. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the Medi-Cal plan to the rest of the Medi-Cal population.
California Health & Wellness and its providers will provide the full range of CHDP services as defined in, and in accordance with, California state regulations and California Department of Health Care Services' policies and procedures for Early and Periodic screening services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and developmental history (including assessment of both physical and mental development)
- Comprehensive unclothed physical examination
- Appropriate behavioral health and substance abuse screening
- Immunizations appropriate to age and health history
- Laboratory tests
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Health education, counseling and anticipatory guidance based on age and health history

Provision of all components of the CHDP service must be clearly documented in the PCP’s medical record for each member through the use and submission of a PM160 form as an encounter.

California Health & Wellness requires that providers cooperate to the maximum extent possible with efforts to improve the health status of California citizens, and to actively participate in the increase of percentage of eligible members obtaining CHDP services in accordance with the adopted periodicity schedules. California Health & Wellness will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the California Immunization Program. **Vaccines must be billed with the appropriate administration code and the vaccine detail code.**

**EMERGENCY CARE SERVICES**

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

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of a bodily function
- Serious dysfunction of any bodily organ or part

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

Emergency services are covered by California Health & Wellness when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by California Health & Wellness. Emergency services will cover and reimburse regardless of whether the provider is in California Health & Wellness provider network and will not deny payment for treatment obtained under either of the following circumstances:

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

Once the member’s emergency medical condition is stabilized, California Health & Wellness requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

Except where copayments are applicable and allowable, provider shall not bill, charge, or collect payment from a member for any emergency care services.

**WOMEN’S HEALTHCARE**

California Health & Wellness will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive healthcare services in addition to the member’s PCP if the provider is not a women’s health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include but are not limited to:

- Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations and sexually transmitted diseases
- Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases
- Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided
• Referral of members to physicians or health agencies for consultation, examination tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases as indicated

• Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and Chlamydia immunizations

• Abortions are a covered service and do not require authorization

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

24/7 COVERAGE

NurseWise® is our 24-hour, seven day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the NurseWise service. Our staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in the community after hours, when the California Health & Wellness, Member Services Department (“Member Services”) is closed. The NurseWise staff is available to talk with you in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or NurseWise at 1-877-658-0305.
CLINICAL PRACTICE GUIDELINES

California Health & Wellness clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, California Health & Wellness adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. California Health & Wellness providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by California Health & Wellness.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations.

For links to the most current version of the guidelines adopted by California Health & Wellness, visit our website at www.cahealthwellness.com.

CARE MANAGEMENT PROGRAM

The California Health & Wellness care management model is designed to help your California Health & Wellness members obtain needed services, whether they are covered within the California Health & Wellness array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

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

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our care management team will integrate covered and non-covered services and provide a holistic approach to a member’s medical, as well as function, social and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care management team is available to help all providers manage their California Health & Wellness members. Listed below are programs and components of special services that are available...
and can be accessed through the case management team. We look forward to hearing from you about any California Health & Wellness members that you think can benefit from the addition of a California Health & Wellness case management team member.

To contact a care manager call:

California Health & Wellness
Care Management Department
Phone: 1-877-658-0305
Fax: 1-855-556-7909
www.cahealthwellness.com

**High Risk Pregnancy Program**

The OB Care Management Team (CM) will implement our Start Smart for Your Baby® (Start Smart) program, which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period and infants through the first year of life. A care manager with obstetrical nursing experience will serve as primary case manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk Members, and recommending interventions. These physicians will provide input to California Health & Wellness Medical Director on obstetrical care standards and use of newer preventive treatments such as Makena (hydroxyprogesterone caproate injection).

California Health & Wellness offers a premature delivery prevention program by supporting the use of Makena injections. When a physician determines that a member is a candidate for Makena, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for Makena. This California Health & Wellness case manager will follow up with the member and complete an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. The care manager can help to coordinate the ordering and delivery of the Makena directly to the physician's office or facilitate a referral to a home visiting program where the member can receive injections in the home. Contact the California Health & Wellness high risk pregnancy department for enrollment in the Makena program.

**Complex Case Management**

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The California Health & Wellness complex teams will manage care for members whose needs are primarily functional as well as those
with such complex conditions. Children with special healthcare needs are at special risk and are also eligible for enrollment in case management. California Health & Wellness will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

A Transplant Coordinator will provide support and coordination for members who need major organ transplants. All members considered as potential transplant candidates should be immediately referred to the California Health & Wellness Case Management Department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the state agency as appropriate.

MemberConnections® Program

MemberConnections is a California Health & Wellness outreach program designed to provide education to our members on how to access healthcare services and develop healthy lifestyles. The program components are integrated as a part of our case management program to link California Health & Wellness members to health and community resources. The program recruits staff from the communities serviced to establish a grassroots support and awareness of California Health & Wellness within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone California Health & Wellness to talk with California Health & Wellness Member Services department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the Connections Representative or their assigned care manager. Community groups may request that a Connections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Connection Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what California Health & Wellness is all about, overview of services offered by California Health & Wellness, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and California Health & Wellness.

Home Connections: Connection Representatives are available for home visits when a need or request from a member or provider arises. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.
**Phone Connections:** Connection Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

To contact the MemberConnections Team, call:
California Health & Wellness
1-877-658-0305

**Chronic Care/Disease Management Programs**

As a part of California Health & Wellness services, Chronic Care Management Programs (CCMP) is offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

**Nurtur**, Centene’s disease management subsidiary, will administer California Health & Wellness chronic care management program. Nurtur’s programs promote a coordinated, proactive, disease-specific approach to management that will improve members’ self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. California Health & Wellness programs include but are not limited to: asthma, diabetes and congestive heart failure.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation. To refer a Member for chronic care management call:

California Health & Wellness
Health Coach
1-877-658-0305

**BILLING AND CLAIMS SUBMISSION**

**General Guidelines**


This manual applies to medical providers only.

California Health & Wellness processes claims in accordance with applicable State prompt pay requirements.

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with California Health & Wellness for payment of covered services. It is important that providers
ensure California Health & Wellness has accurate provider demographic and other information on file. This will ensure accurate and timely claim payment. Please confirm with your Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- Provider name (as should be depicted in the provider directory)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Specialty
- Physical location address (as noted on current W-9 form)
- Billing name and address
- All affiliated practitioners are appropriately loaded and associated with each TIN
- PCP panel status and size is correct

Providers must bill with their rendering NPI along with their group NPI and TIN in the appropriate fields on the claim form to avoid rejections or delays in processing. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the requirements will be returned/rejected to the provider and are not considered clean, therefore cannot be accepted into our system.

We recommend that providers notify California Health & Wellness as soon as possible, but no later than 30 days in advance of changes pertaining to billing and demographic information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member’s contract on the date of service
- Referral and prior authorization processes were followed, if applicable
- All HIPAA billing and CMS coding rules have been followed per the Provider Billing Manual

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual and the Provider Billing Manual located at www.cahealthwellness.com.

**Clean Claim Definition**

“Clean Claim” means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

**Timely Filing**

Providers must submit first time claims not later than the sixth month following the month of service. When California Health & Wellness is the secondary payer, the claims must be received
not later than one year after the month of service to permit the provider to obtain proof of payment, partial payment or non-liability of the carrier. Claims received outside of these timeframes will deny for untimely submission.

A request for adjustment, corrected claim or reconsideration of an adjudicated claim must be received not later than 365 days following the date of payment or denial of the claim. If favorable resolution of a claim is not obtained, a grievance or complaint concerning the processing or payment of the claim must be filed.

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

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

### Electronic Claims Submission

Network providers are encouraged to participate in California Health & Wellness’s electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses California Health & Wellness has partnered with, contact:

California Health & Wellness
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDIBA@centene.com
Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

California Health & Wellness Payer ID is 68047 and we are directly contracted with the following clearinghouses:

- Emdeon
- Gateway
- SSI
- Availity
- Claim Remedi

NOTE: Other clearinghouses not listed above will route claims to California Health & Wellness via one of the above clearinghouses.

Providers not interested in partnering with a clearinghouse for claim submission have the option of submitting HIPAA EDI transactions directly to California Health & Wellness (please contact our EDIBA Help Desk for more information) or electronically via our Secure Provider Portal.

**Paper Claims Submission**

All claims and encounters should be submitted as follows:

First time claims, corrected claims, claim disputes and requests for reconsideration:

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

Claim Disputes:
Claim disputes must be accompanied by the Claim Dispute Form located at [www.cahealthwellness.com](http://www.cahealthwellness.com)

Please see the Provider Billing Manual for detailed information about how to submit corrected claims, requests for reconsideration or claim disputes.

**Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)**

California Health & Wellness offers Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically at no cost to providers. As a Provider, you can gain the following benefits from using EFT and ERA:
Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.

Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow.

Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported.

Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily.

For more information, please visit our provider home page on our website at www.cahealthwellness.com. If further assistance is needed, please contact Provider Services at 1-877-658-0305.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- **90%** of clean claims within **30** business days of receipt or receipt of additional information
- **99%** of all claims within **45** business days of receipt

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker’s compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

California Health & Wellness is always the payer of last resort. California Health & Wellness providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to California Health & Wellness members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform California Health & Wellness that efforts have been unsuccessful. California Health & Wellness will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, California Health & Wellness will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

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

If a provider has a question or is not satisfied with the information they have received related to a claim, there are five effective ways in which a provider can contact California Health & Wellness.
1. Review the claim in question on the secure Provider Portal. Participating providers who have registered for access to the secure Provider Portal can access claims to obtain claim status, submit claims or submit a corrected claim.

2. Contact a California Health & Wellness Provider Service Representative at 1-877-658-0305. Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a simple request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly.

3. Submit an adjusted or corrected claim to California Health & Wellness:
   - Corrected claims must clearly indicate they are corrected in one of the following ways:
     - Submit corrected claim via the secure Provider Portal.
     - Follow the instructions on the portal for submitting a correction.
   - Submit corrected claim electronically via Clearinghouse.
     - Institutional Claims (UB): Field CLM05-3 = 7 and REF*F8 = Original claim number
     - Professional Claims (CMS): Field CLM05-3 = 6 and REF*F8 = Original claim number
   - Mail corrected claims to:
     California Health & Wellness
     ATTN: CORRECTED CLAIMS
     P.O. Box 4080
     Farmington, MO 63640-3835
     - Paper claims must include original EOP with the resubmission.
     - Failure to include the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

4. Submit a “Request for Reconsideration” to California Health & Wellness:
   - Requests for Reconsideration should be mailed to California Health & Wellness at the address below:
     California Health & Wellness
     ATTN: RECONSIDERATIONS
     P.O. Box 4080
     Farmington, MO 63640-3835
     - A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
- The claim form **should not** be resubmitted; however, the claim number must be referenced in the documentation.
- The request must include sufficient identifying information which includes, at a minimum, the patient name and patient ID number, date of service, total charges, provider name and provider tax identification number.
- The documentation must also include a detailed description of the reason for the request.
- Unclear or non-descriptive requests could result in no change in the processing, a delay in the research or delay in the reprocessing of the claim.

5. **Submit a “Claim Dispute Form: to California Health & Wellness:**

- Claim Dispute Forms should be mailed to California Health & Wellness at the address below:
  
  California Health & Wellness  
  ATTN: CLAIMS DISPUTES  
  P.O. Box 4080  
  Farmington, MO 63640-380

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

Providers wishing to dispute a claim must complete the Claim Dispute Form located at: [www.cahealthwellness.com](http://www.cahealthwellness.com).

- To expedite processing of your dispute, please include the original request for reconsideration letter and the response.
- The claim form **should not** be submitted; however, the claim number must be referenced in the documentation.

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

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

If the provider is not satisfied with the final medical claims dispute review, the provider may utilize the Dispute Resolution process as defined in the Participating Provider Agreement or request a fair hearing appeal through the DHCS Office of Administrative Hearings and Appeals.

**PM-160 Form**
The PM 160 form is still required and should be submitted to California Health & Wellness. California Health & Wellness will forward the form to the state and retain information within the
plan as required by state and federal law. Since the form is recognized as an encounter form only, California Health & Wellness requires submission of a claim(s) for payment as outlined in this Provider Manual and the Provider Billing Manual. Please submit PM 160’s at least once a month to the following address:

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

ENCOUNTERS

What is an Encounter Versus a Claim?

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a California Health & Wellness member and receive a monthly capitation amount for services provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data. California Health & Wellness utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a California Health & Wellness member.

Procedures for Filing a Claim/Encounter Data

California Health & Wellness encourage all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters. CHDP services will require a claim for payment and a PM160 for the encounter to be submitted via paper submission directly to California Health & Wellness following the guidance outlined in the Provider Billing Manual.

Billing the Member

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

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

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

_I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under California Health & Wellness as being reasonable and medically necessary for my care. I understand that California Health & Wellness through its contract with the California Department of Health Care Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care._

For more detailed information on California Health & Wellness billing requirements, please refer to the Provider Billing Manual available on the website www.cahealthwellness.com.

CREDENTIALING AND REcredentialing

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the California Health & Wellness, as well as government regulations and standards of accrediting bodies.

_Note: In order to maintain a current provider profile, providers are required to notify California Health & Wellness of any relevant changes to their credentialing information in a timely manner._

Physicians must submit at a _minimum_ the following information when applying for participation with California Health & Wellness:

- Complete signed and dated California Standardized Credentialing application or authorize California Health & Wellness access to the CAQH (Council for Affordable Quality Health Care)
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider’s name, or evidence of compliance with California regulations regarding malpractice coverage or alternate coverage
- Copy of current California Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
• Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
• Copy of current unrestricted medical license to practice in the state of California
• Current copy of specialty/board certification certificate, if applicable
• Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
• Signed and dated release of information form not older than 120 days
• Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
• Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
• Copy of Medicare Certification (if applicable)
• Documentation of a Passed Survey and Medical Records Review Survey in accordance with MMCD Policy Letters, Title 22, CCR Section 53856, and W and I Code 14182(b)(9)
• Disclosure of Ownership & Controlling Interest Statement

California Health & Wellness will verify the following information submitted for Credentialing and/or Re-credentialing:
• Current participation in California FFS Medi-Cal
• California license through appropriate licensing agency
• Board certification, or residency training, or medical education
• National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
• Hospital privileges in good standing or alternate admitting arrangements
• Five year work history
• Federal sanction activity individual, managing employee, business interests and business with transactions over $25,000 against the EPLS and LEIE databases

Once the application is completed, the California Health & Wellness Credentialing Committee (Credentialing Committee) will render a final decision on acceptance following its next regularly scheduled meeting.

**Credentialing Committee**

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

**Note:** Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

**Re-Credentialing**

To comply with accreditation standards, California Health & Wellness conducts the re-credentialing process for providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner’s licensure, sanctions,
certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the California Health & Wellness network.

In between credentialing cycles, California Health & Wellness conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate California State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, California Health & Wellness reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medi-Cal.

A provider’s agreement may be terminated if at any time it is determined by the California Health & Wellness Credentialing Committee that credentialing requirements are no longer being met.

**Right to Review and Correct Information**

All providers participating within the California Health & Wellness network have the right to review information obtained by California Health & Wellness to evaluate their credentialing and/or re-credentialed application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the California Health & Wellness credentialing department. Upon receipt of this information, the provider will have 14 days to provide a written explanation detailing the error or the difference in information to the. The California Health & Wellness Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

**Right to Be Informed of Application Status**

All providers who have submitted an application to join California Health & Wellness have the right to be informed of the status of their application upon request. To obtain status, contact the California Health & Wellness Provider Relations department at 1-877-658-0305.

**Right to Appeal Adverse Credentialing Determinations**

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in the California Health & Wellness network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional...
documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

**Disclosure of Ownership and Control Interest Statement**

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medi-Cal agency, and to managed care organizations that contract with the state Medi-Cal agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to California Health & Wellness within 30 days of the change. The Disclosure of Ownership and Control Interest Statement form is available at [www.cahealthwellness.com](http://www.cahealthwellness.com). Please contact California Health & Wellness Provider Relations Department at 1-877-658-0305 if you have questions or concerns regarding this form.

**Site Visits**

Site visits are a part of the credentialing/re-credentialing process and will be conducted with providers before credentialing is finalized. The full scope facility Site Review includes Medical Records Review in accordance with MMCD Policy Letter 02-02. Site visits are conducted to ensure all PCP, specialists and ancillary providers that deliver services to members:

- Provide appropriate primary health care services
- Carry out processes that support continuity and coordination of care
- Maintain patient safety standards and practices
- Operate in compliance with all applicable federal, state, and local laws and regulations
- Provide physical accessibility for Seniors and Persons with Disabilities

Site visits are performed in accordance with applicable MMCD Policy Letters, Title 22, CCR Section 53856, and W and I Code 14182(b)(9).

**RIGHTS AND RESPONSIBILITIES**

**Member Rights**

California Health & Wellness members have the following rights and responsibilities:

- To be treated with respect giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical information
- To be provided with information about the organization and its services
- To be able to choose a Primary Care Provider within the Contractor's network
- To participate in decision making regarding their own healthcare, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care received
- To receive oral interpretation services for their language
- To formulate advance directives
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Programs, sexually transmitted disease services and emergency services outside the contracted network
- To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible
- To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record
- To disenroll upon request
- To access Minor Consent Services
- To receive written member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with W & I Code Section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand
- To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Section 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State

**Provider Rights**

California Health & Wellness providers have the **right to**:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members’ care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor’s office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members’ treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against California Health & Wellness and/or a member
- File a grievance with California Health & Wellness on behalf of a member, with the member’s consent
- Have access to information about California Health & Wellness quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact California Health & Wellness Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of members
Provider Responsibilities

California Health & Wellness providers have the **responsibility** to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment recommendations, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options

- Allow members to use their California Medi-Cal ID card as proof of enrollment in California Health & Wellness until the member receives their California Health & Wellness ID card

- Treat members with fairness, dignity, and respect

- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency

- Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality

- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility

- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA

- Allow members to request restriction on the use and disclosure of their personal health information

- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records

- Provide clear and complete information to members, in a language they can understand, about their health condition and any treatment recommendations, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process

- Tell a member if the proposed medical care or treatment is part of a research experiment and give the Member the right to refuse experimental treatment

- Refer member to a CCS paneled provider that have sufficient clinical detail to establish or raise a reasonable suspicion that the member has a CCS eligible medical condition

- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal

- Respect members’ advance directives and include these documents in the members’ medical record

- Allow members to appoint a parent, guardian, family member, or other representative if they can’t fully participate in their treatment decisions

- Allow members to obtain a second opinion, and answer members’ questions about how to access healthcare services appropriately
Follow all state and federal laws and regulations related to patient care and patient rights.

Participate in California Health & Wellness data collection initiatives, such as HEDIS and other contractual or regulatory programs

Review clinical practice guidelines distributed by California Health & Wellness

Comply with California Health & Wellness Medical Management program as outlined in this handbook

Disclose overpayments or improper payments to California Health & Wellness

Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status

Obtain and report to California Health & Wellness information regarding other insurance coverage

Notify California Health & Wellness in writing if the provider is leaving or closing a practice

Contact California Health & Wellness to verify member eligibility or coverage for services, if appropriate

Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible

Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language

Not be excluded, penalized, or terminated from participating with California Health & Wellness for having developed or accumulated a substantial number of patients in the California Health & Wellness with high cost medical conditions

Coordinate and cooperate with other service providers who serve Medi-Cal members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school based programs as appropriate

Object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds

Disclose to California Health & Wellness, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between California Health & Wellness and the physician or physician group

GRIEVANCES AND APPEALS PROCESS

Member Grievance and Appeals

California Health & Wellness will establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals that complies with 42 CFR, Part 438, Subpart F and all applicable state and federal laws. California Health & Wellness will refer all members who are dissatisfied with California Health & Wellness or its subcontractors in any respect to the California Health & Wellness Grievances and Appeals Coordinators (Coordinator) to review and respond to grievances and appeals, and implement required corrective action.
California Health & Wellness’s grievance system will include a grievance process, appeal process, and state fair hearing process. The process will not be overly burdensome, California Health & Wellness staff will assist members as needed to file a grievance, appeal or request for State Fair Hearing, and the grievance process will address the linguistic, cultural, and disability access needs of our enrollee population.

Bars
The California Health & Wellness will not create barriers to timely due process. Examples of creating barriers include but are not limited to:

- Including binding arbitration clauses in California Health & Wellness member choice forms
- Labeling complaints as inquiries and funneling into an informal review
- Failing to inform members of their due process rights
- Failing to log and process grievances and appeals
- Failure to issue a proper notice including vague or illegible notices
- Failure to inform of continuation of benefits
- Failure to inform of right to State Fair Hearing

Member Notification of Process
Members will be notified upon enrollment of the procedure for processing and resolving grievances. The notification will explain specific instructions about how to contact California Health & Wellness Member Services Department and will identify the Grievance and Appeals Coordinators as the designated staff who process grievances and appeals. California Health & Wellness notification in the Member Handbook will include information (including all related policies, procedures and timeframes) regarding:

- The grievance system including appeals and State Fair Hearings
- The procedures for filing and resolving grievances
- The telephone number and address for presenting a grievance
- The state’s review process
- The independent medical review system
- DHCS’s toll-free telephone number and website address

Cultural and Linguistic Needs
The Grievance System allows all members to have access to and fully participate in the process, including those with limited English proficiency or with a visual or other communicate impairment.

PROCEDURE:
A) General Requirements

1. **Who can file a grievance or appeal:** A member, or authorized representative acting on the member’s behalf may file a grievance or appeal, and may request a State Fair Hearing. A provider, acting on behalf of the member and with the member's written consent, may file a grievance or appeal.
2. **Method of filing a grievance or appeal**: A member, or member's authorized representative, may file a grievance or appeal verbally or in writing. California Health & Wellness will give members reasonable assistance in completing forms and taking other procedural steps of the Grievance System, including, but not limited to, providing translations of grievance procedures, forms, and plan responses, access to interpreters, as well as telephone relay systems and other resources that facilitate access and communication for members with disabilities.

Grievance forms and a description of the grievance procedure are readily available at each facility, on the California Health & Wellness website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

3. **Intake of a grievance or appeal**: Member Services Representatives (MSR) will document the substance of the grievance or appeal and send it to the Coordinator for processing. If the grievance is resolved by the MSR at the time of submission, the Coordinator will review the resolved case, log it into the tracking database, and send the appropriate letters to the member.

4. **Investigation of a grievance or appeal**: The grievance or appeal will be investigated by the respective staff member. If the grievance is a quality of care or service complaint, it will be routed to the QI Department for investigation and resolution.

5. **Making decisions**: The Plan will ensure that decision makers on grievances and appeals were not involved in previous decision making and that all decision makers are health care professionals with clinical expertise in treating the member's condition when deciding the following:
   - Appeal of a denial based on lack of Medical Necessity;
   - Grievance regarding denial of an expedited resolution of an Appeal; and
   - Grievance or Appeal involving clinical issues.

6. **Notice Of Action**: California Health & Wellness will give the member a formal letter informing her/him that a medical service has been denied, deferred or modified. The Notice of Action will include all of the following:
   - The action that California Health & Wellness and its sub-contractors have taken or intends to take
   - The reason for the action
   - The member's or provider's right to file an appeal
   - The member's right to request a State Fair Hearing
   - The procedures for exercising the member's rights to file a grievance or appeal
   - The circumstances under which an expedited review is available and how to request it
   - The member’s right to have benefits continue pending the resolution of the appeal
   - The procedure for requesting that benefits continue

Resolution letters will be sent in the member’s preferred language. Included in the responses letter will be the following information:

- The result and date of the appeal resolution
- Member’s right to request a State Fair Hearing
• How to request a State Fair Hearing
• Right to continue to receive benefits pending a State Fair Hearing
• How to request the continuation of benefits
• DHCS and DMHC telephone number
• The California Relay Services’ telephone numbers
• The California Health & Wellness telephone number
• DHCS’s internet address
• The statement contained in subsection (b) of Section 1368.02 of the Act

**Punitive Action:** The Plan will assure that no punitive action is taken against a provider who files a grievance, an appeal or requests an expedited appeal on behalf of a member or supports a member’s grievance, appeal or request for an expedited appeal. Furthermore, there will be no discrimination or retaliation against a provider because the provider filed a contracted provider dispute or a non-contracted provider dispute.

**B) Member Grievance Process**

1. **Definition:** The Grievance Process is California Health & Wellness’s procedure for addressing member grievances, which are expressions of dissatisfaction about any matter other than a Notice of Action. A grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, or request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where California Health & Wellness's unable to distinguish between a grievance and an inquiry, it is considered a grievance.

2. **Filing grievances:** The member, member’s authorized representative, or provider (as noted above), may file a grievance orally or in writing, within 180 calendar days of the incident.

3. **Grievance acknowledgement:** A grievance will be acknowledged in writing within 5 calendar days of receipt of the grievance. The acknowledgement will notify the complainant:
   • The grievance has been received
   • The date of the receipt
   • The name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance

4. **Timely Resolution:** Grievances will be resolved in a timely manner that is appropriate for the complexity of the grievance and the member’s health condition.
   • Most grievances should be resolved within 10 business days of receipt or sooner but shall not exceed 30 calendar days from the day California Health & Wellness received the initial grievance request, be it oral or in writing. A written response will be sent at the time of resolution. The written response will contain a clear and concise explanation of the California Health & Wellness decision.
• California Health & Wellness may extend the timeframe for disposition of a grievance for up to 14 calendar days if the member requests the extension or California Health & Wellness demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If California Health & Wellness extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay, status of the grievance and an estimated completion date.

C) Expedited Review of Clinically Urgent Grievances

1. **Process**: California Health & Wellness will maintain an expedited review process for grievances when California Health & Wellness determines the member requests or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

2. **Member grievances to DHCS and DMHC**: Members are notified of the right to contact DHCS and DMHC regarding the grievance. There is no requirement that the member participates in the California Health & Wellness Grievance System prior to applying to the DHCS for review of the urgent grievance.

3. **Notice**: Notice of the expedited grievance does not need to be in writing.

4. **Response time**: Consideration of the member's medical condition is taken into consideration when determining response time.

5. **DHCS and DMHC contact**: DHCS may contact California Health & Wellness regarding urgent grievances 24 hours a day, seven days a week. During normal work hours, California Health & Wellness will respond to DHCS and DMHC within 30 minutes after initial contact from DHCS and DMHC. During non-work hours, California Health & Wellness will respond to DHCS and DMHC within one hour after initial contact from DHCS and DMHC.

6. **Reporting**: California Health & Wellness will provide DHCS and DMHC the following information on urgent grievances:
   a. A description of the system to resolve urgent grievances, including provision for qualified plan representatives to respond to DHCS and DMHC contacts. Provisions include name and titles, telephone numbers and any other numbers, e-mail addresses, etc., as needed for contact.
   b. A description of how DHCS and DMHC may access the Grievance System established by the plan.

D) Member Appeal Process

1. **Definition**: The Appeal process is California Health & Wellness's procedure for addressing member appeals, which are requests for review of a previous decision California Health & Wellness including a grievance determination or a Notice of Action.
2. **Filing an appeal:** A member or provider acting on behalf of a member and with the member’s written consent, may file an appeal orally or in writing. Standard appeal requests must be followed with a written appeal request. Expedited appeals requested orally do not require subsequent written request.

3. **Timely filing of appeal:** An appeal must be filed within 90 calendar days from the date on the notice of resolution or action or within 10 calendar days if the member is requesting to continue benefits during the appeal investigation.

4. **Acknowledgement of receipt of filed appeal:** California Health & Wellness will acknowledge all oral or written appeals in writing within 3 business days of the receipt of a request for an appeal. The letter will include:
   a. Subject of the appeal.
   b. Explanation of the appeal process.
   c. The Member’s rights including the right to submit any comments, documents or evidence relevant to the appeal.

5. **Expedited review of appeals:** California Health & Wellness will maintain an expedited review process for Appeals when California Health & Wellness determines the member requests or the provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life, health or ability to attain, maintain, or regain maximum function.

6. **Right to submit evidence:** California Health & Wellness will allow the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. In the case of an expedited appeal, California Health & Wellness will inform the member of the limited time available for this.

7. **Right to examine appeal documentation:** The member and his or her representative has the right to examine the case file, including medical records, and any other documents and records considered during the appeals process, before and during the appeals process.

8. **Parties to the appeal:** The member and his or her representative or the legal representative of a decease member’s estate, are included as parties to the appeal.

9. **Resolution and notice of appeal:** California Health & Wellness must resolve and issue a written decision to the member of each Appeal within State-established timeframes not to exceed 30 calendar days from the day California Health & Wellness received the initial Appeal request, whether oral or in writing.
   - The notice of resolution shall include the results of the resolution process, the date it was completed and further appeal rights, if any.
   - Under certain circumstances, detailed above in the grievance process, there may be one extension of up to 14 calendar days.

10. **Extension:** Except for an appeal relating to an ongoing emergency or denial of continued hospitalization, the resolution timeframe may be extended by 14 calendar days, if the member...
requests the extension or if the extension is in the best interest of the member. In all circumstances, the appeal resolution will not exceed 30 calendar days from receipt of the request.

11. **Expedited appeal resolution and notice**: Expedited appeals must be resolved and notification made as quickly as the member’s health condition requires.

California Health & Wellness will make reasonable efforts to provide oral notice of expedited appeal resolution to the member immediately after the Appeal decision but shall not exceed 72 hours after California Health & Wellness receives the Appeal request, whether the Appeal was made orally or in writing.

Prior to issuing an adverse determination, the California Health & Wellness Medical Director will contact the requesting provider to obtain additional information. If the Medical Director denies the expedited appeal request, the Grievance and Appeal Coordinator will make reasonable efforts to provide the member with prompt oral notice and a written notice will be sent within three calendar days and the appeal will be transferred to the standard resolution process.

In certain circumstances, California Health & Wellness may extend the Appeal resolution timeframe by up to 48 hours.

E) **State Fair Hearing System**

1. **Who may request State Fair Hearing**: A member, their representative or provider (with the member’s written consent) may request a State Fair Hearing at any time during the Grievance or Appeal process and defined by the state regulations.

2. **Parties to State Fair Hearing**: The parties to a State Fair Hearing include California Health & Wellness, as well as the member, his/her representative or the representative of a deceased member’s estate.

3. **Timeframe for submission of State Fair Hearing**: The request for a State Fair Hearing must be submitted within 90 calendar days from the date of the notice of action regarding their expedited or standard appeal.

   The request must be submitted within 10 calendar days of the date of the notice of resolution, if the member wishes to have continuation of benefits during the State Fair Hearing.

4. **Expedited State Fair Hearing**: This expedited process only applies for a California Health & Wellness denial of a requested service and if the issue involves imminent and serious threat to the member’s health. The decision is made within 72 hours.

5. **Plan cooperation**: California Health & Wellness will cooperate with the state agency in the hearing process and submit a copy of the member’s standard appeal of the California Health & Wellness action; the contents of the standard appeal file including research, medical records and other documents used to make their decision and a summary of the member’s appeal; the evidence used by California Health & Wellness to make its decision; and a copy of the notice of resolution provided to the member and to the State agency within the required timeframe.
F) **Independent Medical Review**

1. **Who may request:** Members may request an independent medical review (IMR) for decisions that California Health & Wellness denied due to its determination the therapy or medical service denied, modified or delayed health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. Members who have presented the disputed health care service for resolution by the Fair Hearing process are not eligible for an IMR.

2. **Definition:** The IMR process resolves decisions that deny, modify or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies.

3. **Eligibility for IMR:** DMHC makes the final decision when there is a question as to whether a dispute over a health care service is eligible for IMR and whether extraordinary and compelling circumstances exist that waive the requirement that the member first participate in the plan’s Grievance System.

4. **How to submit for an IMR:** The form “Independent Medical Review Application” is completed. The member may also provide any relevant material or documentation with the application, including but not limited to:
   a. A copy of the adverse determination by California Health & Wellness or the provider notifying the member that the request for services was denied, delayed or modified based on the determination that the service was not medically necessary.
   b. Medical records, statements from the member’s provider or other documents establishing that the dispute is eligible for review.
   c. A copy of the grievance requesting the health care service or benefit filed with the plan or any entity with delegated authority to resolve grievances, and the response to the grievance, if any.
   d. If expedited review is requested for a decision eligible for IMR, include a certification from the member’s provider indicating that an imminent and serious threat to the health of the member exists and that the proposed therapy would be significantly less effective if not promptly initiated.

5. **Application for an IMR:** The request for an IMR must be filed with DMHC within six months of California Health & Wellness’s written response to the member’s grievance.

Applications will not be rejected as untimely solely because the member, the member’s provider or California Health & Wellness failed to submit supporting documentation.

Requests for extensions or late applications will be approved if a timely submission was reasonably impaired by inadequate notice of the IMR process or by the member’s medical circumstances.

An application is not eligible for IMR if the member’s complaint has previously been submitted and reviewed by DMHC. Exceptions may be approved if the application for IMR includes medical records and a statement from the member’s provider demonstrating significant changes.
in the member's medical condition or in medical therapies available have occurred since DMHC's disposition of the complaint.

6. **Notification**: DMHC will notify the member and California Health & Wellness if an application for IMR has been accepted:
   a. within 7 calendar days of receipt of a routine request
   b. within 48 hours for an expedited review

   The notification will identify the IMR organization, whether the review will be expedited or routine and any other information needed. California Health & Wellness will receive a copy of the member’s application for an IMR.

7. **Required information**: After California Health & Wellness is notified of the IMR application, California Health & Wellness must provide all information related to the disputed health care service, the member’s grievance and California Health & Wellness’s determination, including:
   a. Copy of all correspondence
   b. Complete copy of the medical records used in making the original decision (additional copies for each reviewer)
   c. A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted, if the evidence of coverage was referenced in California Health & Wellness’s resolution of the member’s grievance
   d. California Health & Wellness’s response to any additional issues raised in the member’s IMR application

   California Health & Wellness must promptly provide the member a list of all documents submitted to the IMR along with information on how to request additional copies.

8. **Additional Information**: California Health & Wellness is responsible for providing additional information:
   a. Any medical records or other relevant matters not available at the time of DMHC’s initial notification, or that result from the member’s on-going medical care or treatment for the medical condition or disease under review. Information will be forwarded as soon as possible upon receipt by California Health & Wellness, not to exceed:
      i. Routine cases: five business days
      ii. Expedited cases: one calendar day
   b. Additional medical records or other information requested by the IMR organization will be sent within:
      i. Routine cases: five business days
      ii. Expedited cases: one calendar day

   In expedited review, California Health & Wellness will immediately notify the member and the member’s provider by phone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of California Health & Wellness or its providers.

   DMHC will contact the member or member’s representative if additional information is needed.
9. **Determination of need for IMR:** DMHC will review the information submitted and determine whether the member is eligible for an IMR. The determination will use all information received and the member’s medical condition and the disputed health care service when making the determination.

If DMHC decides not to refer the case for IMR, the request will be considered a complaint or grievance.

The member or the member’s representative and California Health & Wellness will be advised of DMHC’s determination.

10. **Disposition:** Each assigned review will issue a separate written analysis of the case, explaining:

   a. the determination made
   b. how the determination relates to the member’s medical condition and history, medical records, etc., and references to the specific medical and scientific evidence as applicable
   c. may also include the risks and benefits considered

DMHC, the member or the member’s representative may withdraw a case from the IMR at any time. California Health & Wellness may seek withdrawal of the case from the review system by providing the disputed health care service, subject to the concurrence of the member.

**G) Continuation of Benefits**

1. California Health & Wellness must continue the member’s Benefits if all of the following are true:

   a. The member files the appeal in a timely manner, meaning on or before the later of the following:

   b. Within ten calendar days of the date on the notice of action, or

   c. The intended effective date of California Health & Wellness’s intended action

   d. The action involves the termination, suspension or reduction of a previously authorized course of treatment;

   e. The services were ordered by an authorized provider;

   f. The authorized period has not expired; and

   g. The member requests extension of benefits.

2. If California Health & Wellness continues or reinstates the member’s benefits while the appeal is pending, California Health & Wellness must continue providing the benefits until one of the following occurs:

   a. The member withdraws the request for an appeal or State Fair Hearing;

   b. Ten calendar days pass after California Health & Wellness mails the notice providing the resolution of the appeal against the member, unless the member, within the 10 calendar day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;

   c. The State Fair Hearing officer renders a decision that is adverse to the member; and/or

   d. The member’s authorization expires or the member reaches his/her authorized service limits.
3. **Adverse decision to State Fair Hearing:** If the final resolution of the State Fair Hearing is adverse to the member, California Health & Wellness may recover the costs of the services furnished while the State Fair Hearing was pending to the extent that the services were furnished solely because of the requirement to continue benefits during the appeal.

4. **Services not furnished:** If services were not furnished while the State Fair Hearing was pending, and the State Fair Hearing resolution reverses California Health & Wellness’s decision to deny, limit or delay services, California Health & Wellness must authorize or provide the disputed services as quickly as the member’s health condition requires.

5. **Services furnished:** If services were furnished while the State Fair Hearing was pending, and the State Fair Hearing resolution reverses California Health & Wellness’s decision to deny, limit or delay services, California Health & Wellness must pay for disputed services in accordance with State policy and regulations.

**Provider Grievances**

1. **Definition:** A provider grievance is a verbal or written expression of dissatisfaction, including any complaint, dispute, and request for reconsideration or appeal made by a provider. DHCS and DMHC consider a provider complaint or appeal as a grievance.

2. **Process:** A grievance regarding contractual issues or health plan processes will be received by the grievance and appeal coordinator, and tasked for research and resolution. A request for claim reconsideration or claim appeal will be received, logged, researched and resolved by the Claims Appeal Unit.

3. **Resolution:** The Coordinator will attempt to resolve immediately if possible but no longer than 30 calendar days of receipt.

**WASTE, FRAUD AND ABUSE**

**Waste Fraud and Abuse (WFA) System**

California Health & Wellness takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, fraud and abuse (WFA) program that complies with California and federal laws. In accordance with the California Code of Regulations (CCR), Title 22, Section 51460, Special Claims Review may be imposed on a provider upon a determination that the provider has submitted improper claims, including claims that incorrectly identify codes or services provided. California Health & Wellness, in conjunction with its management company, Centene, successfully operates a waste, abuse and fraud unit. California Health & Wellness performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this manual. The Special Investigation Unit (SIU) performs prospective and retrospective audits which, in some cases, may result in taking actions against those providers, individually or as a practice, commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
• More stringent utilization review
• Recoupment of previously paid monies
• Termination of provider agreement or other contractual arrangement
• Civil and/or criminal prosecution
• Any other remedies available to rectify

Some of the most common WFA practices include:
• Unbundling of codes
• Up-coding services
• Add-on codes billed without primary CPT
• Diagnosis and/or procedure code not consistent with the member’s age/gender
• Use of exclusion codes
• Excessive use of units
• Misuse of Benefits
• Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call OIG’s Hotline at 1-800-HHS-TIPS (1-800-447-8477), directly to a Medi-Cal Fraud Control Unit (MFCU), or our anonymous and confidential WFA hotline at 1-866-685-8664. California Health & Wellness and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Please Note: Due to the evolving nature of wasteful, abusive and fraudulent billing, California Health & Wellness and Centene may enhance the WFA program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.

Authority and Responsibility
The California Health & Wellness Director of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. California Health & Wellness is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The California Health & Wellness provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

QUALITY IMPROVEMENT

California Health & Wellness culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and
chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

California Health & Wellness recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, California Health & Wellness will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member’s condition is not amenable to improvement, California Health & Wellness will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the California Health & Wellness QI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Program Structure
The California Health & Wellness Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QI Program and has established various committees and ad-hoc committees to monitor and support the QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the quality improvement (QI), utilization management (UM), and credentialing programs.

The QIC is supported by various subcommittees which may include the following:
- Credentialing Committee
- Utilization Management Committee
- HEDIS Steering Committee
- Performance Improvement Team
- Member, Provider, Hospital and Community advisory committees
- Joint Operations Meetings
- Peer review Pharmacy & Therapeutics Committee

Practitioner Involvement
California Health & Wellness recognizes the integral role practitioner involvement plays in the success of its QAPI Program. California Health & Wellness encourages PCP, specialty, and Pediatrician OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing and Utilization Committee and select ad-hoc committees.
California Health & Wellness also encourages provider engagement through participation in its Provider Advisory committees. If you are interested in participation in a committee please contact Provider Services Department or your Provider Relations Representative.

**Quality Assessment and Performance Improvement Program Scope and Goals**

The scope of the QI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the California Health & Wellness members. California Health & Wellness QI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care at facilities that include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities, and Intermediate Care Facilities and ancillary services.

California Health & Wellness primary QI Program goal is to improve members’ health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the California Health & Wellness QI Program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and re-credentialing)
- Behavioral healthcare (within benefits)
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Health Plan after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety
- Marketing practices
- NCQA Accreditation status
- Quality of care and adherence to guidelines, measured through HEDIS percentages
Patient Safety and Quality of Care

Patient Safety is a key focus of the California Health & Wellness QI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member.

California Health & Wellness employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The California Health & Wellness QIC reviews and adopts an annual QI Program and Work Plan based on managed care Medi-Cal appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow California Health & Wellness to monitor improvement over time.

Annually, California Health & Wellness develops a QI Work Plan for the upcoming year. The QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the- QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.

California Health & Wellness communicates activities and outcomes of its QI Program to both members and providers through avenues such as the Member newsletter, provider newsletter and the California Health & Wellness web portal at www.cahealthwellness.com.

At any time, California Health & Wellness providers may request additional information on the health plan programs including a description of the QI Program and a report on California Health &
Wellness progress in meeting the QI Program goals by contacting the Quality Improvement department.

**Healthcare Effectiveness Data and Information Set (HEDIS)**

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the California State Medi-Cal contract.

As both the California and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. California purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company’s ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices.

**How are HEDIS rates calculated?**

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see California Health & Wellness website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

**Who will be conducting the Medical Record Reviews (MRR) for HEDIS?**

California Health & Wellness will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with California Health & Wellness which allows them to collect PHI on our behalf.
What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure
- Submit claim/encounter data for each and every service rendered - All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-877-658-0305.

Provider Satisfaction Survey

California Health & Wellness conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by California Health & Wellness, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives. Results of the provider satisfaction survey will be made available on California Health & Wellness’s website.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members’ expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.
MEDICAL RECORDS

Medical Records
In accordance with Title 22, CCR, Section 75055, 42, USC 1396a(w), Title 28, CCR, Section 1300.67.1(c), Title 22, CCR, Section 53861, Title 22, CCR, Section 75055, and MMCD Policy Letters 02-02 and 10-016 (as amended), the following are requirements regarding medical records.

- Records shall be permanent, either electronic, typewritten or legibly written in ink and shall be kept on all patients accepted for treatment.
- All medical records of discharged patients shall be completed and filed within 30 days after termination of each episode of treatment and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18, but in no case less than 7 years.
- All exposed X-ray film shall be retained for seven years.
- All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the clinic or any authorized officer, agent or employee of either, or any person authorized by law to make such request.
- Information contained in the medical records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.
- If a provider ceases operation, arrangements shall be made for the safe preservation of the members’ medical records. California Health & Wellness and DHCS shall be informed by the provider of the arrangements within 48 hours before cessation of operation.

California Health & Wellness and DHCS shall be informed within 48 hours, in writing, by the licensee whenever patient medical records are defaced or destroyed before termination of the required retention period.

If the ownership of a provider changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide California Health & Wellness and DHCS with written documentation stating:
  - That the new licensee shall have custody of the members’ medical records and these records shall be available to the former licensee, the new licensee and other authorized persons; or
  - That other arrangements have been made by the current licensee for the safe preservation and the location of the members’ medical records, and that they are available to both the new and former licensees and other authorized persons.

- Members’ medical records shall be current and kept in detail consistent with good medical and professional practice and shall describe the services provided to each member. All entries shall be dated and be authenticated with the name, professional title, and classification of the person making the entry.
- Members’ medical records shall be stored so as to be protected against loss, destruction or unauthorized use.
- Member medical records shall be filed in an easily accessible manner in the clinic. Storage of records shall provide for prompt retrieval when needed for continuity of care. Prior approval of California Health & Wellness and DHCS is required for storage of inactive medical records away from the facility premises.
• The medical record shall be the property of the facility and shall be maintained for the benefit of the member, medical care team and clinic and shall not be removed from the clinic, except for storage purposes after termination of services.

• Providers must delegate an individual to be responsible for the securing and maintaining medical records at each site.

• The medical record must reflect all aspects of patient care, including ancillary services, and at a minimum includes the following:
  o Member identification on each page; personal/biographical data in the record
  o The member’s preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services
  o For member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
  o The record shall contain a problem list, a complete record of immunizations and medical maintenance or preventive services rendered.
  o Allergies and adverse reactions must be prominently noted in the record.
  o All informed consent documentation, including the human sterilization consent procedures.
  o All reports of emergency care provided (directly by the provider or through an emergency room) and the discharge summaries for all hospital admissions.
  o Consultations, referrals, specialists’ pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
  o For medical records of adults, documentation of whether the individual has been informed of their rights to make decisions concerning medical care; to have an advance directive; and if an advance directive such as a Durable Power of Attorney for Medical Care has been executed.

• A complete medical record must be maintained for each member for five years from the end of the fiscal year in which the contract with California Health & Wellness expires or is terminated.

• All medical records must be available for inspection or examination by California Health & Wellness, DHCS, the United States Department of Medical and Human Services, the California Department of Justice or the Comptroller General of the United States or their duly authorized representatives upon their request.

**Medical Records Release**

All member medical records shall be confidential and shall not be released without the written authorization of the member or a member’s legal guardian or authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Providers and community mental health programs must obtain written consent from the member to release information to coordinate care regarding primary care and mental health services or substance abuse services or both.

**Medical Records Transfer for New Members**

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within 10 business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.
All PCPs are required to document in the member’s medical record attempts to obtain historical medical records for all newly assigned California Health & Wellness members. If the member or member’s guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

**Medical Records Audits**

California Health & Wellness will conduct random medical record audits as part of its QI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. California Health & Wellness will provide written notice prior to conducting a medical record review.