



<b>Policy and Procedure No: PR 29.0</b>	<b>Revision No: 0</b>
<b>Division: Care Management</b>	
<b>Department: Provider Relations</b>	
<b>Title: PHC-CA Provider Contracting and Fee Schedule Disclosure</b>	
<b>Effective Date: 10/1/2025</b>	
<b>Supersedes Policy No: N/A</b>	
<b>Reviewed/Revised by: Sandra Holzner</b>	<b>Review/Revision Date: 10/29/2025</b>
<b>Approving Committee: Member Provider Committee</b>	<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>	

**Purpose:**

This policy establishes PHC California’s (the Health Plan) standards and procedures for provider contracting and the disclosure of fee schedules and payment policies. It ensures compliance with the California Knox-Keene Health Care Service Plan Act and the regulations of the Department of Managed Health Care (DMHC). The goal is to promote transparency, consistency, and regulatory alignment in all Network Provider agreements.

**Policy:**

1. The Health Plan must disclose the complete fee schedule to contracting providers in an electronic format at the time of initial contracting.
2. The Health Plan must disclose the complete fee schedule annually thereafter, on or before the contract anniversary date, in an electronic format.
3. The Health Plan must also disclose the complete fee schedule upon the contracted provider’s written request.
4. The Health Plan must disclose detailed payment policies and rules, as well as any non-standard coding methodologies used to adjudicate claims, in an electronic format.
5. These coding methodologies must, when available, be consistent with Current Procedural Terminology (CPT) and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations.
6. The Health Plan must clearly and accurately state what is covered under any global payment provisions, including those for professional and institutional services, services provided as part of a course of treatment in an institutional setting, and other global arrangements such as per diem hospital payments.
7. The Health Plan must clearly and accurately state its policies regarding:
  - a. the consolidation of multiple services or charges and any payment adjustments due to coding changes;
  - b. reimbursement for multiple procedures;
  - c. reimbursement for assistant surgeons;
  - d. reimbursement for the administration of immunizations and injectable medications;
  - e. recognition of CPT modifiers.

8. The Health Plan must ensure that all disclosures are provided in sufficient detail and in a format that is understandable to a reasonable person with appropriate training, experience, and competence in claims processing. These disclosures must not include proprietary trade secret information or violate copyright law or patented processes.
9. The Health Plan may disclose the required information through a secure website, provided that written notice is given to the contracted provider at least forty-five (45) days prior to implementing the website transmission format or posting any changes to the information.

**Procedure:**

1. Initial Contracting

- a. The Health Plan must include the complete fee schedule and detailed payment policies as part of the initial contracting package provided to each Network Provider.
- b. At the time of the initial execution of a provider contract, the Provider Relations Department must provide the fee schedule and payment policies electronically to the Network Provider.
- c. The Provider Relations Department documents the date and method of delivery to the Network Provider in Salesforce.

2. Annual Updates

- a. In collaboration with the Provider Data Management and Provider Relations Departments, the Health Plan reviews and, if necessary, updates the fee schedule and payment policies at least sixty (60) days prior to each contract anniversary date.
- b. The Provider Data Management Department provides the updated information to the Network Provider electronically on or before the anniversary date of the contract.
- c. The Provider Data Management Department records all notices sent to Network Providers.

3. Ad Hoc Requests

- a. Network Providers may submit written requests for the current fee schedule and payment policies at any time.
- b. Upon receiving a written request, Provider Data Management Department electronically provides this information within thirty (30) calendar days.
- c. The Provider Data Management Department documents each request and response, including the date of the request, the date of the response, and the method of delivery.

4. Website Posting

1. The Provider Relations and Contracting Department provides written notice to Network Providers at least forty-five (45) days prior to implementing the website transmission format or posting any changes to the information.

2. The Director of Provider Data Management verifies that the posted information is current, accurate, and consistent with the requirements outlined in the policy.
3. The Health Plan retains all documentation of all website postings and Network Provider notifications.

**Definitions:**

1. Network Provider: means any Provider or entity that has a Network Provider Agreement with the Health Plan, the Health Plan’s Subcontractor, or the Health Plan’s Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

**Monitoring:**

This Policy and Procedure is reviewed and approved at least annually, or sooner if operational or regulatory changes occur, by the Member Provider Committee (MPC).

**Reference:**

1. California Code of Regulations § 1300.71.

**Regulatory Agency Approval(s):**

<b>Date</b>	<b>Version</b>	<b>Regulatory Agency</b>	<b>Purpose</b>	<b>Response</b>
TBD	29.0	Department of Health Care Services (DHCS)	DMHC Filing 20253578-1 for APL 25-007	Pending

