



<b>Policy and Procedure No: PR 10.1</b>		<b>Revision No: 1</b>
<b>Division: Care Management</b>		
<b>Department: Provider Relations</b>		
<b>Title: PHC-CA Provider Manual</b>		
<b>Effective Date: 10/1/2025</b>		
<b>Supersedes Policy No: PR 10.0</b>		
<b>Reviewed/Revised by: Sandra Holzner</b>		<b>Review/Revision Date: 12/12/2025</b>
<b>Approving Committee: Member Provider Committee</b>		<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

To ensure that PHC California (the Health Plan) has an up-to-date, accessible Provider Manual that clearly defines provider network responsibilities, operational and administrative procedures, and regulatory compliance obligations pursuant to Department of Health Care Services (DHCS) and Department of Managed Care Services (DMHC) requirements.

**Policy:**

1. The Health Plan must issue a Provider manual to Network Providers, Subcontractors, and Downstream Subcontractors that includes information regarding:
  - a. Medi-Cal Covered Services and responsibilities
  - b. Basic Population Health Management (Basic PHM);
  - c. Care Coordination for Excluded Services;
  - d. Policies and procedures;
  - e. Quality assurance;
  - f. Quality improvement and monitoring;
  - g. Clinical protocols governing Prior Authorization and Utilization Management (UM)
  - h. Timeliness standards;
  - i. Credentialing;
  - j. Claims (including prohibited claims) and the following information:
    - i. Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation consistent with 28 California Code of Regulations (CCR) § 1300.71(a)(10), instructions for confirming the plan's or the plan's capitated provider's receipt of claims consistent with 28 CCR § 1300.71(c), and a phone number for claims inquiries and filing information;
    - ii. The identity of the office responsible for receiving and resolving provider disputes;

- iii. Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of provider disputes and all claim dispute requirements, the timeframe for the plan's and the plan's capitated provider's acknowledgement of the receipt of a provider dispute and a phone number for provider dispute inquiries and filing information; and
  - iv. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled notice.
- k. Statutes;
  - l. Regulations;
  - m. Telephone access;
  - n. Special requirements;
  - o. Data reporting; and
  - p. Member Grievance, Appeal, and State Hearing process, including:
    - i. Member's right to file Grievances and Appeals, and the requirements and timeframes for filing, including the right to have the Member's Medical Record and to have an Authorized Representative (AR) or Provider appeal on the Member's behalf, with written consent from the Member;
    - ii. Availability of assistance in filing a Grievance, Appeal, or State Hearing;
    - iii. Toll-free numbers to file oral Grievances and Appeals;
    - iv. Member's right to request continuation of benefits during an Appeal or State Hearing;
    - v. Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing; and
    - vi. Member's right to an Independent Medical Review (IMR), if applicable.
2. The Health Plan must ensure the most updated Provider manual is available through Provider portals, the internet, or upon request. When updates are made to the Provider manual, Contractor must notify Network Providers, Subcontractors, and Downstream Subcontractors.
  3. The Health Plan must solicit feedback from Contractor committees including but not limited to the Public Policy and Community Advisory Committee (PPCAC) and Quality Improvement and Health Equity Committee (QIHEC), to inform the development of the Provider manual and clarify new and revised policies and procedures.
  4. The Health Plan must conduct an annual review of its Provider manual and document that the review has been conducted by the PPCAC, QIHEC and Member Provider Committee (MPC).

5. The Health Plan must update its Provider manual annually or at any time to ensure that the information reflects current requirements.

**Procedure:**

1. The Director of Contracting and Provider Relations is responsible for maintaining and updating the Health Plan’s Provider Manual.
2. The Compliance Department reviews applicable DHCS contractual requirements, All Plan Letters, and DMHC regulatory standards on an ongoing basis to determine when updates are needed and notifies the Director of Contracting Provider Relations to updated the Provider Manual.
3. The Compliance submits the revised Provider Manual to the Quality Improvement and Health Equity Committee (QIHEC), the Member Provider Committee (MPC), and the Public Policy and Community Advisory Committee (PPCAC) for review and feedback. Each committee’s review and recommendations are documented in committee meeting minutes. Any feedback is incorporated when appropriate.
4. The MPC performs a final review and approval of the Provider Manual after each respective committee has provided feedback and revisions are made. Once the MPC reviews and approves the Provider Manual it is published to the Health Plan website at:  
<https://positivehealthcare.net/california/phc/providers/pubs/>.
  - a. The Director of Provider Relations and Contracting sends a Provider Notice to all Network Providers, Subcontractors, and Downstream Subcontractors that the Provider Manual has been updated.

**Definitions:**

1. Downstream Subcontractor: means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
2. 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.
3. Subcontractor: means an individual or entity that has a Subcontractor Agreement with the Health Plan that relates directly or indirectly to the performance of Contractor’s obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

**Monitoring:**

Compliance conducts a formal review of the Provider Manual at least once every twelve (12) months. The review assesses regulatory, operational accuracy, verifies all required content is present and considers provider feedback and internal audit findings.



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

**References:**

1. DHCS Contract
2. California Code of Regulations § 1300.71

**Regulatory Agency Approvals:**

<b>Date</b>	<b>Version</b>	<b>Agency/Purpose</b>	<b>Purpose</b>	<b>Response</b>
11/20/2025	10.0	DMHC	Filing 20253578-1, APL 25-007	Comment Letter/Table
	10.1	DMHC	Filing 20253578-3, APL 25-007	Pending

