A Specialty Medi-Cal Managed Care Plan

Provider Manual

Effective August 1, 2026

Contracting and Provider Relations
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Section 1: Introduction

We would like to welcome you to PHC California; as a network provider, you play a very important role in the delivery of health care services to our enrollees.

This Provider Manual is intended as a guideline for the provision of covered services to PHC California enrollees. This manual contains policies, procedures, and general reference information, including the standards of care required by PHC California.

We hope this information will help you better understand the health plan's operations. We look forward to working with you and your staff to provide quality managed health care services to PHC California enrollees.

PHC California is a specialty Medi-Cal managed care plan designed for individuals living with HIV/AIDS. It was created by AIDS Healthcare Foundation (AHF) and the California of Department of Health Care Services (DHCS), the Medi-Cal Managed Care Division in 1994 and serves eligible Medi-Cal beneficiaries who live in Los Angeles County; PHC California transitioned to a Full Risk (Knox-Keene) Medi-Cal Managed Care Plan effective July 1, 2019.

PHC California is AHF's first managed care plan which was followed in 2006 by PHP, a special needs Medicare Advantage plan with prescription drug coverage. PHC California currently operates in Los Angeles County California. Should you ever have questions about PHC California, please contact Contracting and Provider Relations at (888) 726-5411 or capr@aidshealth.org , Monday through Friday, 8:30 a.m. to 5:30 p.m. You may also visit our provider section on our website at www.phc-ca.org/providers.

Section 2: How to Contact the Plan

Contracting/Provider Relations: PHC California 1710 N. La Brea Ave. Los Angeles, CA 90046 capr@ahf.org	**Credentialing:** Tel: (323) 436-5019 Fax: (888) 235-8256
After-Hours Nursing Advice Line: Tel: (800) 797-1717	**Eligibility:** Tel: (800) 263-0067 Fax: (888) 235-8552 Email: php@positivehealthcare.org
Care Coordination: Tel: (800) 474-1434 Fax: (888) 235-8327	**Member Services:** Tel: (800) 263-0067 Fax: (888) 235-8552 Email: php@positivehealthcare.org
Claims Department: Tel: (888) 662-0626 claims@positivehealthcare.org	**Pharmacy Services/** **Pharmacy Technical Help Desk:** Tel: (888) 554-1334 Fax: (888) 238-2244 Email: pharmacyhelpdesk@aidshealth.org
Claim Submissions: Electronic Payer ID: 95422	**Utilization Management:** Tel: (800) 474-1434 Fax: (888) 238-7463 Email: UMCAAuthCoordinators@ahf.org

Section 3: Eligibility and Enrollment

3.1 Plan Eligibility

PHC California is a voluntary prepaid health plan. Enrollees are not subject to cost sharing for medical services and prescription drugs. Eligibility requirements are as follows:

- Residence in Los Angeles County
- Be 21 years of age or older
- Have full-scope Medi-Cal eligibility (no share-of-cost)
- Have a prior AIDS diagnosis, CD4 count less than 200 or 14% or less, or an AIDS defining illness documented in the medical record
- Be assigned an eligible DHCS aid code.

Medi-Cal beneficiaries who are interested in learning more about PHC California or enrolling into the plan should contact Member Services at **(800) 263-0067**. Agents are available Monday through Friday, 8:00 a.m. to 8:00 p.m. TTY users should call 711.

Information about the plan, covered services, and provider and pharmacy networks is available at www.phc-ca.org.

3.2 Eligibility Verification

Member Services provides enrollee eligibility to providers by phone. Providers must verify eligibility for the date(s) of service to ensure plan responsibility for services to be rendered. To check the eligibility of a PHC California enrollee, please call Member Services at **(800) 263-0067**, Monday through Friday, 8:00 a.m. to 8:00 p.m. When your staff calls, please have our enrollee's ID number available to give to the agent. The ID number is on the enrollee's plan ID card.

3.3 Enrollee Identification (ID) Card

PHC California sends an enrollee ID card to each enrollee in the plan at the time of enrollment and whenever the enrollee's PCP assignment changes from what is indicated on the card.

An example of the plan's ID card is below.


Plan (80840) 7013911129

PHC CALIFORNIA

ID No 123456789
Name JANE DOE

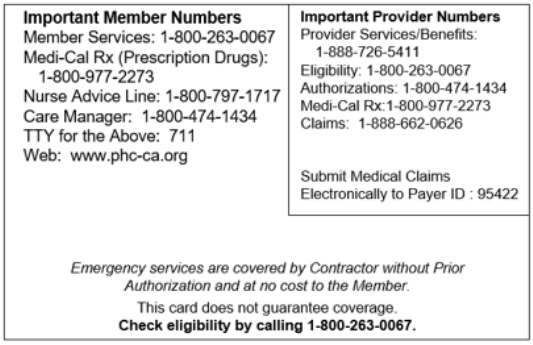
Issue Date MM/DD/YYYY

Your PCP PCP Name, MD
Phone (555) 555-5555

This is your medical services ID card. Show this card to get medical services. You must use your State of California Benefits Identification Card (BIC) at the pharmacy to fill prescription drugs.

DHCS 100223 PHC FR Form 5.7

Front


Important Member Numbers
Member Services: 1-800-263-0067
Medi-Cal Rx (Prescription Drugs): 1-800-977-2273
Nurse Advice Line: 1-800-797-1717
Care Manager: 1-800-474-1434
TTY for the Above: 711
Web: www.phc-ca.org

Important Provider Numbers
Provider Services/Benefits: 1-888-726-5411
Eligibility: 1-800-263-0067
Authorizations: 1-800-474-1434
Medi-Cal Rx:1-800-977-2273
Claims: 1-888-662-0626

Submit Medical Claims Electronically to Payer ID : 95422

Emergency services are covered by Contractor without Prior Authorization and at no cost to the Member.

This card does not guarantee coverage.
Check eligibility by calling 1-800-263-0067.

Back

The plan instructs enrollees to show their PHC California ID card and their Medi-Cal Benefits Identification Card (BIC) whenever they obtain medical services or prescription drugs.

If an enrollee does not have an ID card at the time he/she/they presents to your practice or facility, please call Member Services at **(800) 263-0067**, Monday through Friday, 8:00 a.m. to 8:00 p.m. The plan will verify eligibility and, if necessary, send our enrollee a new ID card.

3.4 New Enrollee Assignment to Primary Care Provider (PCP)

PHC California will notify PCPs when an enrollee is assigned to him or her either through a new enrollment into the plan, or a PCP assignment change at the request of the enrollee or initiated by the plan. PCPs may opt to receive notice via US mail, fax, or secure email. Please contact Contracting and Provider Relations to specify how your primary care practice would prefer to receive notices of new enrollee assignment. Call **(888) 726-5411**, Monday through Friday, 8:30 a.m. to 5:30 p.m. or email capr@aidshealth.org.

a. Enrollee Rosters

PHC California sends enrollee rosters by primary care provider (PCP) assignment to its network PCPs monthly. The roster includes enrollee ID number, address, phone number and enrollment effective date. PCPs may opt to receive the roster via U.S. mail, fax, or

secure email. Please contact Contracting and Provider Relations to specify how your primary care practice would prefer to receive its roster. Call **(888) 726-5411**, Monday through Friday, 8:30 a.m. to 5:30 p.m. or email capr@aidshealth.org.

PCPs should review the roster monthly to ensure each enrollee listed on the roster is a current patient. If any enrollees listed on the monthly rosters are no longer under the care of the assigned PCP or have not seen the PCP within 90 days of appearing on the roster, please advise Member Services by either calling **(800) 263-0067**, Monday through Friday, 8:00 a.m. to 8:00 p.m., or sending a fax to Member Services at **(888) 235-8552**.

b. Enrollee Disenrollment

Enrollees may voluntarily disenroll from PHC California at any time for any reason. Should an enrollee wish to disenroll, he/she/they may contact Member Services at **(800) 263-0067** (TTY 711) Monday through Friday, 8:00 a.m. to 8:00 p.m. Enrollees may also request to disenroll from PHC California by contacting California Department of Health Care Services' (DHCS) enrollment broker, Health Care Options (HCO), at (800) 430-4263, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY users should call **(800) 430-7077**.

Enrollees who wish to leave PHC California will have to choose either LA Care, Health Net, or Kaiser Permanente for their Medi-Cal coverage. Enrollees who wish to enroll in Regular Medi-Cal (fee for-service) must request a medical exemption from plan enrollment from HCO.

PHC California must involuntarily disenroll enrollees from the plan for any of the following reasons:

- Loss of Medi-Cal eligibility;
- Enrollee moves out of the plan's service area, Los Angeles County;
- Enrollee's DHCS-assigned aid code changes to one that is excluded from the plan's contract with DHCS;
- Enrollee qualifies for certain waiver programs that require disenrollment from the plan.

PHC California may involuntarily disenroll enrollees from the plan, subject to approval from DHCS, for the following reasons:

- Enrollee refuses to cooperate with his or her primary care provider (PCP);

- Enrollee repeatedly obtains non-emergency care services from providers outside the PHC California provider network without prior authorization;
- Enrollee behaves in an abusive or violent manner in the presence of PHC California network providers, ancillary or administrative staff;
- Enrollee allows somebody else to use his or her PHC California enrollee ID card or Medi-Cal beneficiary ID card (BIC) to obtain medical services or prescription drugs; or
- Enrollee has been prosecuted and convicted of Medi-Cal fraud involving the inappropriate use of Medi-Cal coverage under the plan.

Should your practice encounter a PHC California enrollee who behaves in an abusive, disruptive, violent or uncooperative manner, please contact Contracting and Provider Relations at **(888) 726-5411**, Monday through Friday, 8:30 a.m. to 5:30 p.m., or fax your concerns to **(888) 235-7695**. Please also contact Contracting and Provider Relations should you wish to discharge an enrollee for behavior issues. When you report an enrollee for behavior issues, please provide the following details:

- Enrollee name and ID number;
- Date(s) of incident(s);
- Description of incident(s) and enrollee's behavior and actions;
- Names and titles of staff members involved in the incident(s);
- Intervention(s) taken to deescalate and redirect the enrollee's behavior; and any counseling or warnings given to the enrollee.

PHC California will work with providers to determine which course of action is most appropriate to address an enrollee behavior problem, such as warning the enrollee that such behavior could be grounds for involuntary disenrollment; reassigning the enrollee to a new PCP or practice, if applicable; moving the enrollee's specialty care to another specialist or practice; or requesting permission from DHCS to involuntarily disenroll the enrollee from the plan.

PHC California requires that network providers consult with the plan prior to discharging any enrollees from their practices.

Section 4: Covered Services

PHC California covers the medical services, equipment, supplies, and prescription drugs listed in the table below and on the following pages. PHC California enrollees are never subject to any copayments or coinsurance for covered services.

Services	Service Description
Acupuncture	PHC California covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of the needles) are covered; limited to two (2) services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services; requires prior authorization.
Alcohol Abuse Treatment	Available through the Drug Medi-Cal Program. PHC California will refer members to **Los Angeles County Public Health Substance Abuse Prevention and Control Program** for such services if necessary. *(By clicking on the link above, you will be taken to a website operated by Los Angeles County Public Health and not PHC California.)*.
Allergy Care	PHC California covers allergy testing and treatment, including allergy desensitization, hypo sensitization, or immunotherapy when medically necessary; no limits; certain services require prior authorization.
Ambulance Services	For emergencies; covered when medically necessary; no limits.
Anesthesiologist Services	Covered when medically necessary; no limits; requires prior authorization.
Audiology Services	Covered when medically necessary; limited to two (2) services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services; requires prior authorization.

Services	Service Description
Behavioral Health/Mental Health Services	PHC California covers Non-Specialty Mental Health Services (NSMHS) and coordinates the provision of carved-out Specialty Mental Health Services (SMHS). Behavioral health treatment includes services and treatment programs, such as applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual; covered when medically necessary; certain services require prior authorization.
Cancer Clinical Trials	PHC California covers a clinical trial if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense, or the Veterans Administration.
Case Management and Disease Management Services	Covered; no limits.
Certified Nurse Practitioner/Physician Assistant Services	Covered when medically necessary; no limits; certain services require prior authorization.
Chiropractic Services	Covered when medically necessary; limited to two (2) services per month in combination with acupuncture, audiology, occupational therapy, and speech therapy services; limited to the treatment of the spine by means of manual manipulation; procedures require prior authorization. Coverage includes manual manipulation of the spine to correct subluxation.

Services	Service Description
Clinical Services from Los Angeles County Health Services Clinics	Primary care and preventive physician services covered; limit of one (1) visit per day.
Clinical Services from Federally Qualified Health Centers (FQHCs)	Primary care and preventive physician services covered; limit of one (1) visit per day.
Clinical Services from Rural Health Clinics (RHCs)	Primary care, preventive physician, and laboratory services covered; limit of one (1) visit per day; certain laboratory services require prior authorization.
Dermatology Services	Covered when medically necessary; no limits; certain services require prior authorization.
Dialysis Services (hospital-based and free standing)	Covered when medically necessary; no limits; requires prior authorization.
Durable Medical Equipment and Medical Supplies	Covered when medically necessary; no limits; certain services require prior authorization.
Emergency Room Services	Covered when medically necessary; no limits.
Enteral and Parenteral Nutrition	These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. Covered when medically necessary; no limits; requires prior authorization.

Services	Service Description
Family Planning Services	Covered; no limits. Available through any participating Medi-Cal provider.
Hearing Aids	PHC California covers hearing aids if you are tested for hearing loss and have a prescription from your doctor; requires prior authorization.
Home Health Care Services *(Includes supplies, appliances, and durable medical gear for use in the home.)*	Covered when medically necessary; no limits; requires prior authorization.
Hospice	Covered for terminally ill members who have a life expectancy of six months or less. Prior authorization not required for routine home care, continuous home care, or hospice physician services. Prior authorization required for general inpatient care.
Immunizations	Covered; no limits.
Inpatient Hospital Services, including Anesthesiologist and Surgical Services	Covered when medically necessary; no limits; certain services require prior authorization. PHC California requires at a minimum that facilities notify the plan within twenty-four (24) hours of admission. Call (800) 474-1434, Monday through Friday, 8:30 a.m. to 5:30 p.m. or send notification via fax to (888) 238-7463. Upon receipt of notification, Utilization Management will request medical records for concurrent review for continued stay authorizations.

Services	Service Description
Investigational Services	Covered when conventional therapies will not adequately treat condition or prevent disability or death; no limits; requires prior authorization.
Laboratory/X-Ray/Imaging Services	Covered when medically necessary; no limits; certain services require prior authorization.
Long-Term Care	Covered; no limits; requires prior authorization.
Major Organ Transplant (MOT)	Effective January 1, 2022, all Medi-Cal Managed Care Plans (MCP) are required to cover the Major Organ Transplant (MOT) benefit for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care. PHC California must authorize, refer and coordinate the delivery of the MOT benefit and all medically necessary covered services associated with MOTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, hospitalization, surgery, discharge planning, readmissions from complications, post- operative services, medications not otherwise covered by the MCP contract, and care coordination for transplants that the MCP is responsible for. PHC California will not be required to pay for costs associated with transplants that qualify as a California Children's Services (CCS) condition if the MCP does not participate in the Whole Child Model (WCM) program. PHC California must also cover all medically necessary covered services for both living donors and cadaver organ transplants. PHC California may authorize MOTs to be performed only in approved transplant programs located within a hospital that meets DHCS criteria.

Services	Service Description
Maternity Services, including: • Delivery and postpartum care • Prenatal care • Diagnosis of fetal genetic disorders and counseling	Covered when medically necessary; no limits; certain services require prior authorization.
Medical Supplies, Equipment and Appliances	Covered when medically necessary; no limits; requires prior authorization.
Medical/Drug Treatment Therapies • Chemotherapy • Radiation Therapy	Covered when medically necessary; no limits; requires prior authorization.
Occupational Therapy	PHC California covers occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction, and consultative services when medically necessary; limited to two (2) services per month, in combination with acupuncture, audiology, chiropractic and speech therapy services; requires prior authorization.
Ophthalmology Services	Covered when medically necessary; no limits; requires prior authorization.

Services	Service Description
Ostomy and Urological Supplies	PHC California covers ostomy bags, urinary catheters, draining bags, irrigation supplies and adhesives when medically necessary; no limits; requires prior authorization.
Outpatient Hospital Services	Covered when medically necessary; no limits; requires prior authorization.
Outpatient Surgery (Hospital-Based)	Covered when medically necessary; no limits; requires prior authorization.
Optometric and Vision Services	Routine eye exam once every 24 months; PHC California may pre-approve (prior authorization) additional services as medically necessary. Eyeglasses (frames and lens) once every 24 months; contact lens when required for medical conditions such as aphakia, aniridia and keratoconus. **Managed by VSP; VSP's Toll Free number is 800-877-7195.**
Outpatient Rehabilitation Services • Cardiac Rehabilitation • Pulmonary Rehabilitation	Covered when medically necessary; no limits; requires prior authorization.
Palliative Care	Covered service; prior authorization required.
Physical Therapy	Covered when medically necessary; no limits; requires prior authorization.
Physician Primary Care Services	Covered; limited to one (1) visit per day.
Physician Specialty Care Services	Covered when medically necessary; limited to one (1) visit per day per specialist; referral and/or prior authorization required.

Services	Service Description
Podiatry Services	Covered when medically necessary; no limits; certain services require prior authorization.
Prescription Drugs	Outpatient prescription drugs dispensed by a pharmacy and billed on a pharmacy claim are carved out to Medi-Cal Rx. Drugs administered by a healthcare professional in a physician's office, clinic, infusion center, hospital outpatient department, or emergency department and billed on a medical claim are covered by PHC California.
Prosthetic and Orthotic Appliances	Covered when medically necessary; no limits; requires prior authorization.
Reconstructive Services	PHC California covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. No limits; requires prior authorization.
Sexually Transmitted Disease (STD) Testing, Counseling and Treatment	Covered, no limits. Available through any participating Medi-Cal provider.
Skilled Nursing Facility Services	Covered when medically necessary; no limits; requires prior authorization.
Speech Therapy	Covered when medically necessary; limited to two (2) services per month in combination with acupuncture, audiology, chiropractic, and occupational therapy; requires prior authorization.

Services	Service Description
Substance Abuse Treatment	Available through the Drug Medi-Cal Program. PHC California will refer members to **Los Angeles County Public Health Substance Abuse Prevention and Control Program** for such services if necessary. (For further information concerning the Los Angeles County Public Health Substance Abuse Prevention and Control Program please review http://publichealth.lacounty.gov/sapc/)
Transgender Services	PHC California covers transgender services (gender-affirming services) as a benefit when they are medically necessary or when the services meet the criteria for reconstructive surgery. Requires prior authorization.
Transplant Services	Kidney transplants are covered when medically necessary; no limits; requires prior authorization. Other major organ transplants are covered under regular Medi-Cal (fee for service) and require disenrollment from the plan.
Transportation (Non-Emergency)	Covered; no limits; plan must arrange transportation to and from plan-approved locations
Expanded Benefits	**Limitations**
Health and Wellness Benefit	PHC California members have the choice of either a gym membership at 24 Hour Fitness ***OR*** up to $200 worth of **over-the-counter (OTC) pharmacy** items every calendar year for no cost.

4.3 Enhanced Care Management

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to select members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. Through ECM, members can also be connected to Community Supports services to help address their health-related social needs, such as access to healthy foods or safe housing to help with recovery from an illness. ECM is available to PHC California members in the following specific groups (called "Populations of Focus"):

- Adults experiencing homelessness

- Adults who are at risk for avoidable hospital or emergency department care
- Adults with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization
- Adult nursing facility residents transitioning to the community
- Adults transitioning from incarceration
- Pregnant and postpartum individuals; birth equity population of focus

There is no cost to the member for ECM services. Members must opt-in the receive ECM services; PHC California's ECM team contacts members who qualify to get consent. If you have a patient you want to refer for possible ECM services, please contact PHC California's Utilization and Case Management department at **(800) 474-1434**, Monday through Friday, 8:30 a.m. to 5:30 p.m. or fax **(888) 238-7463.**

4.4 Community Supports

Community Supports are services provided by PHC California to address members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. Members may receive a Community Supports service if they meet the eligibility criteria, and if PHC California determines the Community Supports service is a medically appropriate and cost-effective alternative to services covered under the California Medicaid State Plan.

PHC California offers the following Community Supports:

- Community Transition / Nursing Facility Transition to a Home
- Environmental Accessibility Adaptations
- Home Meals / Medically Tailored Meals
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Housing Transition Navigation Services
- Nursing Facility Transition / Diversion to Assisted Living Facilities
- Personal Care Services
- Recuperative Care (Medical Respite)
- Transitional Rent

There is no cost to the member for Community Supports services. Members must opt-in to receive Community Supports. If you have a patient you want to refer for possible Community Supports

services, please contact PHC California's Utilization and Case Management Department at **(800) 474-1434,** Monday through Friday, 8:30 a.m. to 5:30 p.m. or fax **(888) 238-7463.**

4.5 Services Available Through Medi-Cal Fee-for-Service (FFS)

The following services are available to PHC California enrollees through Medi-Cal FFS. PHC California Care Managers are available to assist members with care coordination of services available through Medi-Cal fee-for-service (FFS) system:

Dental services such as the following below are available through Denti-Cal.

- Exams and x-rays
- Cleanings (prophylaxis)
- Deep cleanings (scaling and root planning)
- Fluoride treatments
- Fillings
- Laboratory and prefabricated crowns
- Partial dentures
- Root canals in front and back teeth
- Full dentures
- Other medically necessary dental services

If medically necessary, dental services may exceed the yearly $1,800 limit.

PHC California enrollees who require dental services should contact Denti-Cal at **(800) 322-6384 (TTY (800) 735-2922)** or visit denti-cal.ca.gov.

4.6 Excluded Services

The following services are not covered by PHC California or regular Medi-Cal:

- Experimental procedures
- Cosmetic surgery (except when required to repair trauma or disease related disfigurement)
- Drugs and medications when used for cosmetic purposes
- Common household items which can be used as durable medical equipment

- Routine non-medically necessary foot-care services
- Personal comfort or convenience items, such as, but not limited to, telephones, televisions, and guest trays
- Erectile dysfunction drugs or therapies

4.7 Limitations

PHC California will make all reasonable attempts to provide covered services; however, it is not responsible for a lapse in care under the following conditions:

- Delay or failure to render service due to major disaster or epidemic affecting facilities or personnel;
- Interruption of services due to war, riot, labor disputes, or destruction of facilities; or
- Failure to provide service when a member has refused a recommended service for a personal reason and/or when a plan provider believes no professionally acceptable alternative treatment exists.

Questions of medical appropriateness or necessity of treatment will be subject to review by PHC California's Medical Director who will consider all opinions and determine whether services are covered by the contract.

4.8 Transportation

PHC California covers emergency (ambulance) transportation and coordinates and arranges non-emergency medical and non-medical transportation for its enrollees as follows:

- **Emergency transportation** is covered when an enrollee's medical or physical condition is acute and severe and requires immediate diagnosis and treatment so as to prevent death or disability. Emergency transportation may be provided via ground or air ambulance.

If an enrollee presents in a facility and experiences a medical emergency requiring hospitalization, the attending practitioner must arrange emergency transportation by a licensed ambulance company to the nearest emergency room or call 9-1-1 to obtain ambulance service.

- **Non-emergency medical transportation (NEMT)** is covered when prescribed in writing by a physician, dentist, behavioral health provider, etc. for an enrollee to obtain medically necessary covered services. NEMT is subject to prior authorization, except

when an enrollee is transferred from an acute inpatient facility to a SNF. PHC California may provide NEMT through:

1. Ambulance
    a. Transfers between facilities for enrollees who require continuous intravenous medication, medical monitoring, or observation.
    b. Transfers from an acute care facility to another acute care facility.
    c. Transport for enrollees who have recently been placed on oxygen (does not apply to enrollees with chronic emphysema who carry their own oxygen for continuous use).
    d. Transport for members with chronic conditions who require oxygen if monitoring is required.

2. Litter van service when an enrollee's medical and physical condition does not meet the need for NEMT ambulance but meets both the following:
    a. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period needed to transport.
    b. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance.

    Provider must submit a signed Physician Certification Statement (PCS) form to PHC California for all litter van transport requests.

3. Wheelchair van services when an enrollee's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    a. Renders the enrollee incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
    b. Requires that the enrollee be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation, such as paraplegia or severe mental confusion.
    c. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance.
    d. Dialysis recipients
    e. Enrollees with chronic conditions who require oxygen but do not require monitoring.

Provider must submit a signed Physician Certification Statement (PCS) form to PHC California for all wheelchair van transport requests.

4. Air service only when transportation by air is necessary because of the enrollee's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or behavioral health or substance use disorder provider.

- **Non-medical transportation (NMT)** is provided to enrollees so that they may obtain medically necessary services, including those not covered PHC California, but available through Medi-Cal FFS or Los Angeles County providers. NMT does not include transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations. PHC California may authorize NMT for an enrollee who uses a wheelchair, but whose limitation is such that the enrollee is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the enrollee's needs. PHC California provides NMT in a form and manner that is both physically and geographically accessible for the member and is consistent with applicable State and federal disability rights laws.

  PHC California provides round-trip transportation for an enrollee by passenger car, taxicab, bus, train, or any other form of public or private conveyance (including a private vehicle). NMT also includes mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the enrollee and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

  Round-trip NMT is available for the following:

  1. Medically necessary services, including those not covered under the Contract.
  2. Members picking up drug prescriptions that cannot be mailed directly to the member.
  3. Members picking up medical supplies including prosthetics, orthotics, or other equipment.

  Enrollees who wish to book NMT should call Member Services at **(800) 263-0067**, Monday through Friday, 8:00 am to 8:00 pm. TTY users should call 711.

4.9 PCP Scope of Services Requirements

A PCP is required to provide the following services to members assigned to them:

- Conduct an initial health assessment of new members
- Detect, diagnose, and effectively manage common symptoms and physical signs.
- Treat and manage common acute and chronic medical conditions.
- Perform ambulatory diagnostic and treatment procedures (injections, aspirations, splints, minor suturing, etc.)
- Periodic health assessments including history and physical examinations appropriate for the age, sex, and medical history of the patient.
- Preventive medical care including health risk identification, reduction, and periodic screening.
- Foster health promotion and disease prevention (age-specific screening, health assessment and health maintenance activities, health education and promotion, etc.).
- Provide medical case management (refer to community resources and available supplemental programs, coordinate care with specialists, etc.). Refer to specialists appropriately.
- Follow required procedures for specialist, diagnostic, or service referral as promulgated by PHC California.

Section 5: Member Rights and Responsibilities

This document explains the rights of PHC California members, as stated verbatim in the Member's Membership Services Guide. Providers and their office staff are encouraged to be familiar with this document, post in their office (poster provided by PHC California) and are expected to abide by these rights. PHC California's member rights and responsibilities are as follows:

5.1 Member Rights

A PHC California member has the right to:

- To be treated with respect, with PHC California giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about PHC California and its services
- To be able to choose a Primary Care Provider within PHC California's network
- To participate in decision making regarding your own health care, including the right to refuse treatment
- To file grievances and appeals, either verbally or in writing, about the organization or the care received (Please see Section 11, Grievances and Appeals for specifics.)
- To receive oral interpretation services for your language
- To formulate advance directives
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the Federal law
- To request a state Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible, the availability of assistance in filing for a hearing, continuation of benefits during a hearing, and the representation rules at a Hearing. (Please see Section 11, Grievances and Appeals for specifics.)
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record
- To dis-enroll upon request
- To access minor consent services

- To receive written Member informing materials in alternative formats, including Braille and large size print upon request
- 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 your condition and ability to understand.
- The freedom to exercise these rights without adversely affecting how you are treated by PHC California, your provider, or the State.

5.2 Member Responsibilities

Members have the responsibility to:

- Participate in your health care and the health care of your family. This means taking care of medical problems before they become more serious.
- Keep in touch with and regularly visit your PHC California Primary Care Physician (PCP)/doctor.
- Cooperate with your PCP/doctor, follow his/her instructions regarding your care, and take all of your doctor-prescribed medications as directed.
- Arrive on time for your doctor visits. Call if you will be late or need to cancel/reschedule your appointment.
- Be courteous and cooperative to people who provide you or your family with health care services.
- Not let anyone else use your PHC California ID card or Medi-Cal (BIC) card or pretend to be you.
- Not participate in Medi-Cal fraud or any inappropriate use of your Medi-Cal coverage through PHC California or Medi-Cal fee-for-service.
- Be proactive in your health care. Let us know how you like our Plan and how we can improve our services. Participate in our Satisfaction Survey, Client Advisory Committee, and Public Policy meetings. Help us ensure that we are providing you with the highest quality of health care.

5.3 Member Confidentiality

According to PHC California's Medi-Cal Member Rights, members have the right to full consideration of their privacy concerning their medical care program. They are also entitled to confidential treatment of all member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the member or his/her authorized legal representative must be obtained before

medical records are released to anyone not directly connected with his/her care, except as permitted or necessitated by the administration of the health plan.

5.4 Office Confidentiality Procedure

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any confidential patient information to unauthorized persons. This procedure should be composed of the following elements:

- Written authorization obtained from the member, or his/her legal representative, before medical records are made available to anyone not directly participating in his/her care, except where otherwise permitted or required by law or subpoenas not in conflict with applicable federal or state law. Note that under California Civil Code § 56.109, health care providers cannot release medical information about a person who is seeking or receiving gender-affirming health care or gender-affirming mental health care in response to certain subpoenas or legal requests. Please contact Provider Relations for more information.
- All signed authorizations for release of medical information must be carefully reviewed for authorization information and for any limitations to the release of medical information.
- Each medical record should be reviewed prior to making it available to anyone other than the member or legal representative or the member.
- Only the portion of the medical record specified in the authorization should be made available to the requester and should be separated from the remainder of the member's medical records.
- Any portion of the medical record not indicated by the authorization will be omitted.

5.5 Release of Medical Information Forms

All Providers must maintain a proper release of medical information form for each record request within the patient's medical records.

5.6 Confidential Information

Confidential information also refers to any identifiable information about a member's character, conduct, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. More than the medical record constitutes, conversations, whether in a formal or informal setting, e-mail, faxes, and letters are other potential sources of confidential member information. Member confidentiality must be maintained at all times when providing health care services and during claims processing.

5.7 Confidentiality & Non-Retaliation Notice

Consistent with California SB 497, all employee communications regarding workplace concerns, complaints, or protected activity are treated as confidential to the extent permitted by law. Retaliation, intimidation, or adverse action against any individual for raising concerns, participating in an investigation, or exercising protected rights is strictly prohibited. Reports may be made without fear of reprisal. For further information please click on the link: https://legiscan.com/CA/text/SB497/id/2844685

5.8 Member Satisfaction Survey

PHC California or the State of California, conducts an annual satisfaction survey of its Medi-Cal members. The purpose of the survey is to gather information from members regarding their perception of the health plan; their health care, practitioners, access to care and health plan customer service. The data is used to identify systemic issues that need to be addressed.

Section 6: Access Standards

PHC California is committed to ensuring **timely access to care** for all members. The **Access to Care Standards** outlined below must be observed by **all contracted providers** to ensure compliance with regulatory requirements and to promote high-quality, accessible care for our members.

6.1 Appointments with the Primary Care Physician (PCP)

Members are instructed in their orientation materials to contact their Primary Care Provider Office or Health Care Center (HCC) to schedule routine or urgent/emergency appointments. HCCs are responsible for ensuring timely access to care for Health Plan members. When specialty care is needed, the HCC is responsible for coordinating all services beyond the scope of its practice

6.2 Access Standards

Access standards have been developed to ensure that all health care services are provided in a timely manner. These standards are based on community norms and Medi-Cal standards PHC California monitors the PCP's compliance to the standards. Appointment and waiting time standards are listed below:

Type of Care	Standard (Measured from Time of Request)
Emergency/Urgent Care	Immediate response or outgoing voicemail message must instruct members to call 911 or go to the nearest Emergency Room for emergent services.
Urgent Care Appointment – Services that Do Not Require Prior Auth.	Within 48 hours
Urgent Care Appointment – Services that Require Prior Auth.	Within 48 hours
Primary Care Appointment (Non-Urgent)	Within 10 business days
Specialist including Ancillary Appointment (Non-Urgent)	Within 15 business days
After Hours Services	Outgoing voicemail message must instruct members to call

	911 or go to the nearest Emergency Room for emergent services.
Physical Exam/Preventive Care	Within 30 calendar days of request
First Prenatal Visit	Within 2 weeks
Initial/Staying Health Assessment	Within 120 days of enrollment

6.3 After-Hours Care and Emergencies

The Health Care Center designee must be available **twenty-four (24) hours a day, seven (7) days a week**.

PHC California requires a practitioner or a registered nurse under his/her supervision to maintain a **twenty-four (24)-hour** phone service, **seven (7) days a week**. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room.

After hour phone calls or pages must be returned within **thirty (30) minutes**.

6.4 In-Office Wait Time

Members should not be required to wait more than **thirty (30) minutes** beyond their scheduled appointment time, except in cases where emergency situations unavoidably disrupt the provider's schedule.

6.5 Primary Care Office Hours

Generally, office hours are from 8:30 a.m. to 5:00 p.m.; however, Providers have flexibility to maintain reasonable and regular office hours. All primary care sites are required to post their regular office hours. Providers are expected to maintain consistent office hours for all patients, regardless of insurance type or eligibility for services.

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

The facility must have procedures in place to enable access to emergency services twenty-four (24) hours a day, seven (7) days a week. Facility staff must be knowledgeable of all emergency procedures and capable of effectively coordinating emergency services as needed.

Emergency Equipment and Preparedness Requirements

Providers are expected to maintain emergency equipment that is **easily accessible** and appropriate for the procedures performed and the patient population served. The following requirements apply:

- An **emergency inventory list** must be **posted** and must include **expiration dates** for all emergency drugs.
- Examples of required emergency medications include **epinephrine** and **diphenhydramine (Benadryl)**.
- **Oxygen tanks** must be **secured, full**, and equipped with a **functional flow meter**.
- An **oxygen mask and nasal cannula** must be properly attached and ready for use.
- **Oral airways** and appropriately sized **Ambu Bags** must be available for the patient population served.
- In the event of a medical emergency requiring **Basic Life Support (BLS)** or **Emergency Medical Services (EMS)**, providers must dial **911** immediately.

6.7 Facility Access for the Disabled

PHC California ensures that participating Health Care Centers provide access for disabled members in accordance with the Americans with Disabilities Act (ADA) of 1990. Access should include availability of ramps, elevators, modified restrooms, designated parking spaces close to the facility, and drinking water provisions.

6.8 Monitoring Access for Compliance with Standards

PHC California regularly monitors and audits the appointment and access standards identified in this Section, and others per applicable rules, regulations, contracts, and guidance. PHC California conducts quarterly random appointment checks to determine if the providers' offices meet access standards. This may be accomplished through periodic surveys and/or test calls. A random sample of contracted Providers offices are selected for the survey. Results of the survey are distributed to the providers after its completion. Contracted providers are responsible for responding to any appointment and/or access deficiencies identified by PHC California review methods, including the following:

- Access to care survey's
- Facility Site Review (FSR)
- Exception reports generated from Member grievances
- Medical records review
- Random Member surveys

- Feedback from PCP regarding other network services (i.e., pharmacies, vision care, hospitals, laboratories, etc.)
- Provider office surveys or visits including but not limited to, routine care, urgent care, preventative care, after-hours information, and secret shopper.

6.9 Timely Access to Care: Sensitive and Confidential Services for Adolescents and Adults Sensitive Services

PHC California is committed to ensuring timely access to **sensitive and confidential services** for both adolescents and adults, in accordance with state and federal laws. Sensitive Services include, but are not limited to:

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

The following information outlines procedures for ensuring member access to **sensitive services**.

6.10 Timely Access to Services and Treatment Consent

Members **under the age of twelve (12)** require **parental or guardian consent** to receive services related to **sexually transmitted diseases (STDs)** or **drug and alcohol abuse**. Minors under twelve (12) seeking **abortion services** are subject to **applicable state and federal laws** governing consent.

Minors aged **twelve (12) and older** may independently access all of the above sensitive services—including **STD services, drug/alcohol treatment, abortion care, and reproductive health services**—by signing an **Authorization for Treatment** form, in accordance with **California law**.

Providers are required to ensure **timely access** to **sensitive medical services**, including:

- **Family planning**
- **STD screening and treatment**

- **HIV testing and counseling**
- **Confidential referrals** for **drug and alcohol abuse treatment**

These services must be coordinated promptly, consistent with **timely access standards** and **confidentiality protections** under applicable state and federal regulations.

6.11 Family Planning Services

To support care coordination, Primary Care Providers (PCPs) are encouraged to refer members to Plan Providers for family planning services. However, in accordance with federal law, members are not required to obtain prior authorization from their PCPs and may access family planning services from any qualified provider.

Your contract includes an additional provision regarding Out-of-Network Family Planning Services, as detailed below:

Members of childbearing age may obtain the following services from out-of-network family planning providers for the purpose of temporarily or permanently preventing or delaying pregnancy:

- Health education and counseling to support informed decision-making and understanding of contraceptive options
- A limited history and physical examination
- Laboratory testing, if medically indicated, to assist in the selection of appropriate contraceptive methods. *Note: The Contractor is not required to reimburse out-of-network providers for pap smears if the Contractor has already provided these services in accordance with U.S. Preventive Services Task Force (USPSTF) guidelines.*
- Diagnosis and treatment of sexually transmitted diseases (STDs), as defined by the Department of Health Care Services (DHCS), when medically indicated
- Screening, testing, and counseling for individuals at risk for HIV, along with referrals for treatment when necessary
- Follow-up care for complications arising from contraceptive methods provided or prescribed by the family planning provider
- Provision of contraceptive pills, devices, and supplies
- Tubal ligation
- Vasectomy

- Pregnancy testing and counseling

6.12 Missed Appointments

PHC California contracted providers are responsible for ensuring appropriate follow-up on missed appointments. PHC California physicians must have a process in place to follow-up on missed appointments that includes at least the following:

- Notation of the missed appointment in the Member's medical record
- Review of the potential impact of the missed appointment on the Member's health status including review of the reason for the appointment by a licensed staff member of the physician's office (RN, PA, NP, or MD)
- Notation in the chart describing follow-up for the missed appointment including one of the following actions:
    - No action is required if the missed appointment has no impact on the Member; however, a phone call or written communication to the member should be made, as appropriate, based on the nature of the appointment and the potential health implications of the missed visit. The chart entry must be signed or co-signed by the Member's assigned PCP or covering physician.
- If this missed appointment places the member's health status at significant risk, the provider must make a minimum of three (3) outreach attempts, including at least one (1) telephone call and one (1) written communication by mail
    - Examples of members potentially at significant risk include those with serious chronic conditions, those with clinically significant test results (e.g., critical laboratory findings), and those whom the treating physician determines to be at risk based on clinical judgment
    - All outreach attempts must be documented in the member's medical record, and copies of any written correspondence must be retained

6.13 Emergency Care Services

Emergency Services are defined as services required to evaluate and stabilize an emergency medical condition.

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

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

Emergency services using the prudent layperson definition or that meet Title 28, CCR Section 1300.67(g), and Title 22, CCR, Section 53216 criteria for an emergency do not require prior authorization. In accordance with California Department of Health Services policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and PHC California will pay the Medical Screening Exam fee.

Emergency room staff are required to notify PHC California's Utilization and Care Management Department of a member's emergency room visit by calling **(800) 474-1434**.

6.14 Emergency Room Discharge and After-Care

After care instructions should be documented in the emergency facility medical record and clearly communicated to the patient, parent or legal guardian. Discharge from the emergency facility is performed on the order of a practitioner.

6.15 Notification Requirements

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

6.16 After Hours Nursing Advice Line

PHC California delegates after hour advice for members to Citra. Access to the advice line is available to all members. Licensed nurses provide the services:

- Advise and refer members to appropriate level of care in a timely manner
- Coordinate the member's care with the physician
- Notify physicians of member's ER visit and need for future care
- Educate members on health issues

- Assist in identifying members who might benefit from care management.

Members can contact the PHC California Urgent Care/Nursing Advice Line at **(800) 797-1717**. The line is available after PHC California's standard business hours of 8:30 a.m. to 5:30 p.m. PST, Monday through Friday, **twenty-four (24) hours a day on weekends and PHC California holidays**.

PHC California Holidays include:

- New Year's Day
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving
- Christmas

Section 7: Utilization Management

Utilization Management (UM) is an on-going process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of health care services for PHC California members.

Licensed utilization management staff is responsible for obtaining all pertinent clinical indications and medical record information necessary to perform thorough assessments of requested referrals and service authorizations. The licensed UM staff is responsible for application of utilization review criteria/guidelines to each individual case and for referral to the Medical Director when criteria are not met.

7.1 Admission Review

The UM Department staff are responsible for reviewing submitted clinical documentation on all prior authorization requests. UM staff will make at least three (3) outreach attempts to obtain additional clinical documentation if the submitted request does not contain sufficient information to make a favorable decision. This information is obtained via fax **within twenty-four (24) hours of admission** (or next business day) to ensure the admission to an acute care hospital is appropriate/medically indicated in accordance with the illness or condition and confirm information obtained during prior authorization of elective admissions. Medial record review is required on all emergency inpatient admissions to determine medical necessity.

7.1.1 Notification of Admissions

All elective and emergency inpatient admissions must be reported to PHC California **within forty-eight (48) hours of the admission** (or the next business day).

These notifications can be submitted by faxing the patient's admission face sheet to PHC California UM Department Fax: **(888) 238-7463**.

Providers who have access to our E-Health Solutions Authorization Provider Portal may submit directly to the Portal.

7.2 Concurrent/Continued Stay Review

Concurrent/Continued Stay Review is a process coordinated by the Utilization Management representative during a member's course of hospitalization to assess the medical necessity and appropriateness of continued confinement at the requested level of care. Hospital UM staff must fax the following clinical documentation to support the continued stay:

- Daily Clinical Review
- Emergency Room Report
- Discharge Plan (to begin at time of admission)
- Progress notes (including Admission History & Physical (H&P))
- Consults (including Psychiatric H&P/MSE, as applicable)
- Medication Administration Record
- Lab Results (including culture studies)
- Diagnostic tests (i.e. Radiology, CT, MRI)

Clinical updates must be submitted daily via fax to the Utilization Management Department at (888) 238-7463.

7.3 Discharge Planning Review & Submission of Discharge Information

Discharge planning begins within **twenty-four (24) hours** of notification of the inpatient admission. Such planning is designed to identify quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, PHC California UM staff, including its Medical Director, ancillary providers, and community resources to coordinate care and services.

Discharge Information must be submitted to Utilization Management on the day of discharge but no later than **forty-eight (48)** hours from the day of discharge. Discharge Information includes the following documents but not limited to:

- The practitioner responsible for member's care during their inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Testing Results: this includes documentation of pending tests or indicates member has no pending tests
- Discharge Medication List
- Discharge Instructions: this includes instructions for the PCP or ongoing care provider for the member's care post-discharge
- Post discharge orders for medical goods and services, e.g., home health, DME supplies, infusion services, rehab services, etc.

Discharge information may be faxed to the Utilization Management Department at **(888) 238-7463.**

Discharge summaries must be submitted to the Utilization Management Department no later than **thirty (30) calendar days** from the date of discharge.

7.3.1 Retrospective Review

Retrospective Review is a review process performed by the PHC California UM and/or Claim Review staff and Plan Medical Director, after services have been rendered, to determine:

- If unauthorized services were medically necessary/appropriate
- If services were rendered at the appropriate level of care and in a timely manner
- If any quality-of-care issues exists
- If provider claims appeals are in order

The attending physician, and/or hospital/facility is notified in writing of the claim payment determinations via the "Explanation of Benefits."

7.4 Ancillary Services (Home Health, Durable Medical Equipment, Hospice)

Referrals for any ancillary services including Home Health and Durable Medical Equipment require authorization from the Utilization Management (UM) Department.

7.5 Skilled Nursing, Long Term Care or Rehabilitation Facility Review

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

7.6 Referral Process Purpose of Prior Authorization

Prior authorization is designed to promote the medical necessity of service, to prevent unanticipated denials of coverage and ensure that participating Providers are utilized and that all services are provided are medically necessary and at the appropriate level of care for the member's needs.

The following services typically require prior authorization:

- Elective Inpatient admissions
- Hospital Admissions via the Emergency Department require notification of admission within **one (1) business day**.

- Outpatient surgeries (except where otherwise specified, i.e., abortions, minor office procedures)
- Major Diagnostic Tests, e.g. MRI, CT scan, Angiography
- Endoscopies
- Durable Medical Equipment
- New Medical Technology (considered investigational or experimental) - includes drugs, treatment, procedures, equipment, etc.
- Home Health Care
- Medical Specialty Referrals
- Non-Participating Practitioners/Non-Contracted Facilities
- Chiropractic (limited to treatment of the spine by means of manual manipulation and to a maximum of two (2) services per calendar month
- Acupuncture is limited to treatment of chronic pain to a maximum of two (2) services per month
- Vision Services

PHC California does not require referral or prior authorization for the following services:

- Primary care provider (PCP) visits
- Preventive care services
- Urgent or emergency care services, including behavioral health services and substance use disorder services
- Confidential HIV testing and counseling
- Treatment of sexually transmitted infections
- Family planning services
- Obstetrics/gynecology care
- Therapeutic and elective pregnancy termination
- Initial mental health assessment
- Sensitive and confidential services (e.g. services related to sexual assault, drug and alcohol abuse for children aged 12 and over). Note the Health Plan is not contracted to enroll individuals under the age of 21.

- Services provided by certified nurse practitioners (CNPs) within the scope of their practice as authorized by California law.
- Chiropractic services when rendered by a chiropractor, limited to a maximum of two services per calendar month. Authorization is required for chiropractic services that exceed the two-visit per month limit. A referral may be required when chiropractic services are provided by out-of-network FQHCs, RHCs, and IHCPs.
- Route Eye Exams
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) are viewed as preventive services. In instances where the Medi-Cal Provider Manual outlines immunization criteria that are less restricted than ACIP criteria, the Health Plan provides the immunization in accordance with the less restrictive Medi-Cal Provider Manual criteria.

Referrals and requests for prior authorization of services are sent by Providers to the PHC California Utilization Management Department by portal, fax, mail, and/or telephone based on the urgency of the requested service.

PHC California Utilization Management
Prior Authorization Services/Referrals
Telephone: **(800) 474-1434**
Fax: **(888) 272-7656**
Mail: PHC California
1710 N. La Brea Ave.
Los Angeles, CA 90046

Providers are required to supply the following information, if applicable, for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Clinical indications necessitating service or referral
- Pertinent medical history, and treatment, laboratory data
- Location where service will be performed
- Requested length of stay (inpatient requests)

Pertinent data and information is required by the UM staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization.

7.7 Eligibility

Authorization is based on member eligibility at the time of service and is verified by the Utilization Management staff, by the Eligibility representatives in Member Services or by Medi-Cal's automated Eligibility Verification System (AEVS).

7.8 Benefits

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

7.9 Referral to Non-Participating Practitioners or Non-Contracted Facilities In-Area

Except in true emergencies, PHC California provides coverage for only those services rendered by contracted Providers and facilities. The exceptions are:

- PHC California is notified, approves, and authorizes the referral in advance. In these instances, the UM Outpatient Services/Referrals Department will issue an authorization number for the services to be provided. Prior approval must be obtained by the Provider recommending an out-of-plan referral before arrangements have been made for those services. To obtain an authorization number, please contact the PHC California Utilization Management Outpatient Services/Referrals Department at **(800) 474-1434**. Authorization requests may also be submitted via fax to **(323) 436-5032** or **(323) 436-5033**.
- The patient's medical condition necessitates specialized or unique services that are available only through a non-contracted provider or facility. In such cases, PHC California will assist the referring provider in identifying appropriate specialists or facilities with the required capabilities. All such referrals must be authorized in advance by PHC California.

7.10 Referral Form

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

For a referral to be valid the following conditions must be met:

- The member must be currently enrolled with PHC California.
- The member must be assigned to the PCP initiating the primary referral.
- Authorizations are valid for **ninety (90) calendar days**.

- A Prior Authorization number must be obtained from PHC California prior to services being rendered as described above (except in emergencies).

7.11 When Referral Forms and Notifications Are Required

Procedures not related to the admitting diagnosis (or presenting symptom/diagnosis in the Specialist's office) require prior authorization by PHC California. PHC California retains the right to retrospectively review inpatient and specialist claims to identify inappropriate consultations and procedures. The right to deny such consultations and procedures is also reserved.

Inpatient Admission Notification Fax: **(888) 272-7656**, Phone: **(800) 474-1434**

7.12 Completion of a Referral Form

A thoroughly completed Referral Form is essential to assure a prompt authorization.

- A copy of pertinent clinical notes may be attached and substituted for the Clinical History segment of the Referral Form if the required information is present on those clinical notes.
- The form should be transmitted by fax to PHC California for review by the Utilization Management Department and assignment of an authorization number:
    - Fax: **(888) 272-7656**.
- To assure maximum benefit from a referral, the PCP must clearly state the purpose of the referral and desired services. Patient progress notes, labs, and imaging should be attached to the referral.
- Referral appointments to specialists must be on the same day for emergency care, within **three (3) days for urgent care** and **within thirty (30) days for routine care.**

7.13 Prior Authorization Requests - Primary Care Practitioners (PCPs)

- The PCP is always the initial source of care for members. A member may see the PCP without a referral and the PCP may perform essential services in the office environment.
- Prior Authorization is required for necessary member services ordered by the PCP, which cannot be performed in the office
- If the PCP determines that a specialist is necessary for consultation or care of the patient, the PCP must complete a Referral Form (see below) and obtain a Prior Authorization Number for that referral (unless the service does not require prior authorization as described above)

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

7.14 Specialists Referrals

- A specialist may see a PHC California member only upon an initial referral from the member's assigned PCP or as a secondary consultant from the primary referred specialist along with the approved prior authorization from UM (Medical emergencies excluded)
- If there is any question regarding the scope of the referral, the PCP should be contacted for clarification
- The PCP will specify the type of referral:
    - Consultation for diagnostic purposes
    - Consultation to recommend treatment plan
    - Consultation and request to assume care
- When the member is referred for "Consultation to Recommend Treatment Plan" the PCP will specify on the referral form to UM if:
    - The referral is for a consultation visit only, or
    - The referral is for consultation plus one follow up visit
- Only those diagnostic procedures, tests, and treatments specifically related to the consultation and not defined in the services/referral guidelines, may be performed by the Specialist. This authorization is obtained directly by the specialist following PHC California's prior authorization policies and procedures.
    - Tests, procedures, and treatments must be performed in network facilities
    - This type of referral is valid for a **ninety (90) day period**
- This authorization is obtained by the PCP following PHC California Prior Authorization policies and procedures. Such tests, procedures, and treatments must be performed in network facilities. This referral is valid for ninety (90) days (unless otherwise specified on

the Referral Form).

- If the specialist determines that a secondary specialist who is out of the PHC California Network is required, a Medical Review is required

NOTE: PHC California is **ONLY** financially responsible for those services that are Medically Necessary and specified in the Referral form by the PCP to Specialist (or Referred Specialist to Secondary Specialist) and have been Prior Authorized by PHC California.

Verbal communication from the PCP should be provided on any urgent referrals.

A written response from the specialist should be provided to the PCP within **three (3) weeks** of care for inclusion in the member's medical record.

The Prior Authorization/Referral number must be clearly written on the bill submitted to PHC California:

Attention: Claims Department
PHC California
P.O. Box 46160
Los Angeles, CA 90046

If the member is Medicare eligible or has other insurance, submit the claim to that entity first, then to PHC California with the appropriate Explanation of Benefits.

7.15 Prior Authorization Decision Turnaround Time Standards

- Determinations regarding requests for elective services/procedures are made within **seven (7) calendar days** of request.
- Determinations regarding urgent service/procedures are made within **seventy-two (72) hours** of receipt of request. If the request does not meet medical urgency, the UM department will downgrade the status to standard and notify the provider and member accordingly. In the notification, UM will include the member and provide adverse benefits determination process. The PHC California Medical Director makes the final determination to downgrade any authorization from urgent to standard.
- The Provider will be notified of the decision within **one (1) calendar day** of the decision.
- A list of resources/guidelines used to make utilization and clinical decisions includes, but is not limited to:

- Medi-Cal Provider Manual, Policies and Procedures
- InterQual
- US Preventive Services Task Force
- US Department of Health & Human Services (DHHS) Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB)
- Agency for Healthcare Research & Quality (AHRQ)
- American Geriatric Society
- American Diabetes Association
- American Cancer Society
- American Academy of Pediatrics
- Medicare Local Care Determinations (LCD) for duals
- Medicare National Care Determinations (NCD) for duals
- American College of Obstetrics and Gynecology (ACOG) Guidelines
- Department of Health and Human Services (DHHS), HRSA-HAB Guidelines for HIV/AIDS Primary Care
- Clinical Practice Guidelines adopted by Utilization Management Committee (UMC) as approved by the physician's Medical Administration Policy & Procedure Committee.

Providers who wish to discuss denial or modification of services may contact the PHC California Medical Director at **(800) 474-1434**.

Clinical Criteria used in a denial or modification decision may be requested by calling **(800) 474-1434.**

7.16 Provider Referral Tracking System

Providers can track and monitor referrals requiring prior authorization:

1. Staff model providers may access the electronic medical record system, which contains in detail the status of the referral or contact UM as indicated in #2.
2. Contracted providers may contact the Utilization Management Department directly at **(800) 474-1434.**

7.17 Continuity of Member Care

PHC California and its affiliated health plans and contracted providers must ensure that members receive medically necessary health care services in a timely manner without undue interruption.

The cornerstone of continuity of care is the maintenance of a single, confidential medical record for each patient. This record includes documentation of all pertinent information regarding medical services rendered in the Primary Care Practitioner's (PCP) office or other settings, such as, hospital emergency departments, in-patient and outpatient hospital facilities, specialist offices, the patient's home (home health), laboratory and imaging facilities.

Providers must have systems in place to ensure the following:

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

PHC California does not provide incentives to PHC California Staff for UM decision-making.

7.18 Routine Medical Care

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

7.19 Referrals

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates

the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Upon initiation of the referral, the PCP is responsible for initiating the referral tracking system.

7.20 Second Medical/Surgical Opinion

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

- PHC California members may request a second opinion through their PCP or PHC California's Utilization & Care Management Department. PHC California's Utilization & Care Management Department will assist the member in coordinating the second opinion request with the member's PCP and specialist.
- If the requested specialty care provider or service is not available within the PHC California network, an approval to an out of network provider will be facilitated by PHC California's Utilization Management Department

Under the authorization process utilized by the Utilization Management Department, any medical or surgical procedure that does not meet medical policy criteria (refer to on-line InterQual criteria) is reviewed with a Medical Director. The Medical Director may request a second opinion at any time on any case deemed to require specialty practitioner advisor review. The Utilization Management review criteria may be obtained upon request to the Utilization Management Department.

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

7.21 Continuity of Care When a Practitioner Contract is Terminated

- Members shall be notified at least **thirty (30) calendar days** prior to the effective date of a practitioner contract termination, or within fourteen **(14) calendar days** prior to the change in cases of unforeseeable circumstances. In cases of unforeseeable circumstances, the Compliance Department will coordinate with the Regulatory Contract Managers for approval. PHC California will adhere to the most stringent regulatory standard for all lines of business.
- This policy shall encompass all members assigned to a PCP or that have been treated by a Specialist Practitioner any time during the **eight (8) months** preceding the effective termination date, currently in treatment or open authorizations

- PHC California shall arrange for, upon request by the member or a practitioner on behalf of the member, for continuity of care by a terminated practitioner who has been providing care for:
    - An acute condition (defined as medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration)
    - Serious chronic condition (defined as a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: (a) persists without full cure or worsens over an extended period of time, and (b) requires ongoing treatment to maintain remission or prevent deterioration
    - High-risk pregnancy and/or pregnancy that has reached the second or third trimester
- For cases involving an acute condition or a serious chronic condition, PHC California will continue to provide the member with health care services in a timely and appropriate basis from the terminated practitioner for up to **ninety (90) days** or a longer period if necessary for a safe transfer to another practitioner as determined by PHC California's Medical Director, in consultation with the PCP, and terminated practitioner, consistent with good professional practice
- For cases involving pregnancy, PHC California shall furnish the member with health care services on a timely and appropriate basis from the terminated practitioner, until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another practitioner as determined by PHC California's Medical Director, in consultation with the PCP, and terminated practitioner, consistent with good professional practice
- Continuity of care during an inpatient admission shall be reviewed and determined by PHC California's Medical Director in consultation with the PCP, and terminated practitioner
- Continuity of care for outpatient services, outstanding and ongoing authorizations, for a terminated practitioner, shall be reviewed by PHC California's Medical Director in consultation with the PCP and other practitioners involved with the patient's care.

7.22 Care Management Programs & Services

PHC California provides a comprehensive Care Management program to all members. Care Management (CM) focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of care.

Care Management is individualized to accommodate a member's needs. In collaboration with and approval by the member's Primary Care Practitioners (PCP), the PHC California RN Care Team Manager will arrange individual services for members whose needs include ongoing medical care, home health care, hospice care, rehabilitation services, and preventive services. The PHC California RN Care Manager is responsible for assessing all members and notifying the PCP of the evaluation results, as well as making recommendation for a treatment plan.

The RN Care Manager works in conjunction with the PCP, the member, the member's family, other providers, etc., to coordinate and implement the individualized treatment plan of members.

- PHC California adheres to Case Management Society of America (CMSA) Standards of Practice Guidelines in its execution of the program.
- The PHC California RN Care Manager, in conjunction with the PCP and other providers, develops and implements a care plan appropriate to the member's medical needs.
- Care Management services are not delegated to medical groups.
- The CM Program is based on a member advocacy philosophy designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

Basic Population Health Management (BPHM) is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier, at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all Plan members receive BPHM, regardless of their level of need. BPHM includes access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs), wellness and prevention programs, chronic disease programs and programs focused on improving maternal health outcomes. The Plan, in collaboration with the PCP, follows all members through telephone outreach, telehealth, or face to face visits to ensure all members have access to and are utilizing primary care. Positive screenings in the assessment result in more in-depth surveys and follow-up and a higher stratification level. BPHM is described to qualifying members as Basic Care Management. Members do have the ability to opt out of the program but understand they will be able to receive care management for utilization such as hospitalization. The required elements of BPHM are addressed as follows:

i. Access, Utilization, and Engagement with Primary Care

   To ensure all members have access to and are utilizing primary care the RNCTM and Care Coordination Team:

- Ensure members have an ongoing source of primary care
- Ensure members are engaged with their assigned PCPs (such as helping to make appointments, arranging transportation, and providing health education on the importance of primary care)
- Identify members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity
- Develop strategies to address different utilization patterns
- Ensure non-duplication of services.
- Culturally and Linguistically Appropriate Services (CLAS) standards are followed by all Plan staff. Annual educational courses are required including Applying Concepts of Cultural Competency (2 parts). The Language line is available for use by all staff to ensure that communication can be completed in the member's preferred language.

Complex Care Management (CCM) PHM provides members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. The Plan approach to CCM, as part of our Chronic Care Model, will integrate with the PHM model to provide CCM. There are multiple avenues of referrals to CCM, including, but not limited to, self/caregiver referrals, provider referrals, referrals from Utilization Management, Care Management, or Enhanced Care Management staff, and referrals from facility discharge planners. Members do have the ability to opt out of the program but understand they will be able to receive care management for utilization such as hospitalization.

Every member receiving CCM is assigned a care manager. The role and responsibilities of the RNCTM / CCM Care Manager coordinate the Interdisciplinary Care Team (ICT), oversee the comprehensive Health Risk Assessment process, which includes identifying and closing any gaps in care, leads the development and implementation of the member's individual care plan (ICP), implementation of ICP interventions, monitor member progress in the attainment of ICP goals, provide direct educational support and coordinate group educational experiences with the Health Educator, and integrate the ICP with the Care Coordination team to produce a fully integrated approach to individual member care coordination. He or she must maintain a current RN license. Responsibilities and oversight include:

- Care coordination focused on longer-term chronic conditions
- Interventions for episodic, temporary member needs
- Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education
- Community Supports, if available and medically appropriate, and cost-effective
- Coordinate and lead the ICT
- Coordinates care management between medical and behavioral health providers, members of the ICT and the member
- Direct members' care through the ICP
- Educates the member on self-management and supports the member in empowering them to become active participants in determining their plan of care.
- Conducts an HIF within ninety (90) days and an HRA within forty-five (45) days of enrollment
- Conducts an annual HRA within a year from the members' last HRA
- Conducts nursing assessments when there are significant changes in the member's health status outside of the standard annual HRA. Assign Acuity level (risk assessment) based upon the HRA algorithm and clinical expertise which determines the minimum frequency of member contacts
- Develops an ICP based upon the HRA, transition or change in health condition with input from the member, member family/support system where appropriate, medical providers, ICT and allied health providers.
- Facilitates and monitors the implementation of the individualized care plan interventions and attainment of goals.
- Provides education and reinforcement of techniques to self-manage chronic medical and behavioral health conditions
- Facilitates access to specialists and treatment as needed or when requested
- Makes referrals to behavioral health providers and collaborates with behavioral health care management as appropriate
- Coordinates care across different settings and providers to ensure non-duplication of services
- Works with member to schedule or facilitate scheduling appointments and follow-up services when necessary.
- Assures care and pharmacotherapy are delivered as planned by the interdisciplinary team
- Triage members' care needs
- Identify and facilitate access to community resources and social services
- Advocate, inform and educate members on services and benefits
- Conducts Medication Therapy Management Program processes (Comprehensive Medication Review) as part of an Initial Health Risk Assessment and as clinically necessary.
- Assesses members' medication adherence and communicates needs to medical provider when necessary.
- Consults and collaborates with Plan Pharmacist as part of ICT and for medication concerns as needed.

- Participates in the Transition of Care (TOC) process. Educates members on transition plans, and contacts or visits patients transitioning from acute care settings.

Documents all member encounters through session notes in the care management software system.

Enhanced Care Management (ECM)

ECM is a statewide managed care benefit that addresses the clinical and non-clinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services.

- The Health Plan contract with ECM providers to ensure that eligible members receive community-based, interdisciplinary, high touch, person-centered services that are primarily through in-person interactions
- The Lead Care Manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home

Transitional Care Services

The Health Plan provides strengthened TCS for all members across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports.

- Members are assigned to an RNCTM, who serves as a single point of contact, and assists members throughout their transition and ensures all required services are completed and addressed in this policy under Member Safety/outcomes across different settings
- The RNCTM performs TCS tasks such as ensuring that medication reconciliation is completed upon discharge by the discharging facility, and that every member has follow-up care by a provider, including another medication reconciliation completed post-discharge to reduce medication discrepancies, errors, and adverse drug events
- Emergency Department (ED) visits are included in TCS

Community Services

- **Home and Community-Based Services (HCBS) Programs**
  The Health Plan conducts Health Risk Assessments (HRAs) to identify members eligible for HCBS, including CBAS, MSSP, and IHSS. HCBS referrals are integrated into the care management workflow for members with LTSS needs. The Health Plan coordinates with community-based organizations to facilitate warm handoffs and closed-loop referrals.

- **In-Home Supportive Services (IHSS)**
  The Health Plan identifies members receiving ≥195 IHSS hours/month through DHCS data feeds and stratified them as high-risk. The Health Plan conducts outreach to ensure members had access to care coordination and transitional care services. The Health Plan also

collaborates with county IHSS offices to align service plans with medical needs and reduce duplication.

- **Indian Health Care Providers (IHCPs)**
  While PHC California does not currently serve members who identify as American Indian/Alaska Native (AI/AN) within Los Angeles County, the Plan remains committed to inclusive and culturally respectful practices. PHC California actively participates in collaborative tribal health meetings and regional forums to stay informed about tribal health priorities, service models, and emerging needs. These engagements help inform internal policy development, support cultural competency training for staff, and ensure readiness to serve AI/AN members should enrollment demographics shift.

- **Justice-Involved Reentry Coordination**
  All members receive a Health Risk Assessment (HRA) upon enrollment, which includes questions designed to identify justice-involved status or recent reentry from incarceration. The Health Plan's care management infrastructure is prepared to support justice-involved members through coordinated access to behavioral health, substance use disorder treatment, housing supports, and primary care services.

- **Managed Care Liaisons**
  The Health Plan designates Managed Care Liaisons (MCLs) to serve as points of contact for county agencies, IHCPs, and reentry programs. The Health Plan shall develop interagency communication with county organizations to ensure seamless care coordination and member transitions across systems.

Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports & Carved Out Services

To ensure seamless experience for members, the RNCTM and Care Coordination Team:

- Ensure members have access to services addressing developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

- Partner with primary care and other delivery systems to guarantee that members' needs are addressed. This includes:

  - Ensuring that each member's assigned PCP plays a key role in coordination of care

  - Ensuring each member has sufficient care coordination and continuity of care with out-of-network providers

- Communicating with all relevant parties on the care coordination provided
- Assisting members in navigation, provider referrals, and coordination of health and services across health plans, settings, and delivery systems

- Coordinate warm handoffs with local health departments and other public benefits programs, as specified in collaborative Memorandums of Understanding (MOUs) with county agencies.

Closed-Loop Referrals

To increase the share of members successfully connected to the services they need the RNCTM and Care Coordination Team:

- Utilizes a closed loop referral (CLR) process to identify and close gaps in referral practices and service availability
- Ensure that referrals that are initiated on behalf of a member are tracked, supported, monitored and results in a known closure

Information Sharing and Referral Support Infrastructure

The RNCTM and Care Coordination Team ensure that information sharing and a referral support infrastructure are met using the EMR when appropriate to care, a weekly Interdisciplinary Team Meeting (ICT) and case management software system.

Integration of Community Health Workers (CHWs) in PHM

CHWs may be able to address a variety of health and health-related issues, including, but not limited to: supporting members' engagement with their PCP, identifying and connecting members to services that address SDOH needs, promoting wellness and prevention, helping members manage their chronic disease, and supporting efforts to improve maternal and child health. CHWs may include individuals known by a variety of job titles, including promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals

- Community Health Workers are integrated into the Care Coordination team and provide support as outlined in Community Health Worker guidelines and detailed in the Plan's Policy and Procedure PHC-CA 41.0 Community Health Worker Service Benefit and are outlined in the CHW Integration Plan (see **Attachment** "A").

Wellness and Prevention Programs

The Health Plan provides comprehensive wellness and prevention programs that, at minimum, meet NCQA requirements, including offering evidence-based self-management tools that include, but are not limited to, Smoking Cessation programs, exercise, healthy eating, managing stress, at-risk alcohol use and identifying depressive symptoms. The HRA addresses these areas and are re-enforced when members are contacted.

Programs Addressing Chronic Disease

- The Health Plan offers evidence-based disease management programs in line with NCQA requirements at a minimum. The PCP, RNCTM and Care Coordination team incorporate health education interventions, identify members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions with a focus on improving equity and reducing health disparities. These programs specifically address HIV/AIDS, diabetes, cardiovascular disease, asthma and depression, at minimum.

- Chronic Disease and Maternal Health are part of the Model of Care and Plan Policy and Procedure PHC-CA Chronic Care Model and PHC-CA Provisions of Service for Pregnant Women. Plan members' specific needs (members have a diagnosis of HIV/AIDS), targeted care related to HIV is embedded in the care management of all co-morbidities including Diabetes, Cardiovascular disease, Asthma and Depression. Because of the HIV/AIDS diagnosis, all pregnant members are considered high-risk and are referred to an OBGYN specialist for care. For those members, care management continues by the RNCTM with focus on maternal health. Members do have the ability to opt out of the program, but understand they will be able to receive care management for utilization such as hospitalization

7.23 Referral to Medical Care Management

Unlike many other care management models, **all PHC California enrollees are eligible** for Care Management services. Each enrollee is assessed to determine their **level of acuity** and the **appropriateness of Care Management interventions**. A **referral from the Primary Care Provider (PCP) is not required** for participation in the Care Management program

7.24 PCP Responsibilities in Care Management

The member's PCP is the primary leader of the health team involved in the coordination and direction of care services for the member. The PHC California Case Manager provides the PCP with reports, updates, and information regarding the member's progress through the Care Management plan.

The PCP is responsible for the provision of preventive services and for the primary medical care of members eligible for or requiring “carved out” services. The PCP is responsible for early identification of members eligible for “carved out” services and for referrals to specialist/ancillary providers.

Section 8: Claim & Encounter Data

Unless otherwise stated in this Manual, PHC California follows Medi-Cal guidelines for claims processing and payment. These guidelines are contained in the Medi-Cal Provider Manual.

The Department of Managed Health Care (DMHC) has set forth regulations establishing certain claims settlement practices and the process for resolving claims disputes for managed care products regulated by the DMHC.

This section describes PHC California's requirements for provider claims settlement practices and provider disputes.

8.1 Claim Definitions

- Complete Claim – under the California Code of Regulations section 1300.71, a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides information necessary to determine payer liability.
- Clean Claim — as defined by DHCS, a "clean claim" is defined as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, and; a claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d) or circumstance requiring special treatment that prevents prompt payment, and; a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
- Unclean Claim – Unclean claims include those with incomplete or missing required information. Claims that contain complete and necessary but invalid information are also unclean. Valid information may be required for all claims or may be required on a conditional basis.
- Invalid Information – Claims that include required or conditional information that is illogical, or incorrect (e.g. incorrect Tax ID or NPI when effective) or that is no longer in effect (e.g., and expired number).
- Timely Filing Limit — the claim's "Timely Filing Limit" is defined as the calendar day period between the claim's last date of service, or payment/denial by the primary payer, and the date by which PHC California must first receive the complete claim.
- Received Date — the "Received Date" is the oldest PHC California date stamp on the complete claim received. Acceptable date stamps include any of the following:

- PHC California Claims department date stamp,
- Primary payer claim(s) payment/denial date

8.2 Initial Claim Submission

Providers are encouraged to submit claims to PHC California electronically. PHC California's clearinghouse vendor is Change Healthcare and its electronic payer I.D. 95422

All initial claims must be submitted electronically within **ninety (90) calendar days** from the date of service, or as specified in the provider's written contract and in accordance with California Welfare and Institutions Code §14109.5 and DHCS All Plan Letter (APL) 25-007.

Failure to comply with timely filing requirements may result in claim denial, unless good cause for the delay can be clearly demonstrated and substantiated.

Complete claims shall be reimbursed in accordance with applicable California law and the terms of the provider contract.

- Complete claims are paid within **thirty (30) calendar days** of receipt.

The Health Plan acknowledges electronic claims: within two (2) working days of receipt and paper claims within fifteen (15) working days of receipt. The acknowledgement of receipt discloses the recorded date of receipt by PHC California. Acknowledgement notices are delivered in the same manner the claim was submitted, or through a mutually agreed method (e.g., phone, website, or electronic) that allows the provider to confirm receipt and the recorded date of receipt.
Providers may verify claim receipt by contacting PHC California's Claims Department via email at claims@positivehealthcare.org (ensure all Protected Health Information is transmitted securely), or by calling **(888) 662-0626.**

A complete claim must contain all data elements necessary to determine payment liability and must be free from any indication of fraud, misrepresentation, or abuse. PHC California reserves the right to request supporting documentation when such concerns are identified. If a claim or a part thereof is denied by the Health Plan, the plan notifies the provider within thirty (30) calendar days after receipt of the claim. The notification identifies the portion of the claim that is denied by procedure and revenue code, and the specific information needed from the provider for the Health Plan to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim. If a claim or a part thereof is contested by the Health Plan, the plan notifies the provider within thirty (30) calendar days after receipt of the claim. The notification identifies the portion of the claim that is contested by procedure and revenue code, and the specific information needed from the provider for the Health Plan to reconsider the

claim, including any defect or impropriety or additional information needed to adjudicate the claim.

PHC California will adjudicate complete claims, which is a claim or portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider.

Claims must be submitted to PHC California with the appropriate documentation. The requirements for documentation are designed to streamline the claims payment process. Submission of complete, timely claims allows PHC California to process the claims with a minimum of manual handling.

Providers are encouraged to review the most current Department of Health Care Services (DHCS) billing requirements and the Medi-Cal Provider Manual prior to claim submission to promote efficient claims processing and ensure regulatory compliance.

Submission Options:

Option 1: Electronic claim submission is the preferred method and should be submitted through PHC California's clearinghouse using Submitter ID **95422**.

Option 2: If electronic submission is not feasible, paper claims may be faxed to **(888) 235-9274**.

Claims Submission Requirements (for all CMS-1500 and UB04 claims)

1. Provider name and address
3. Patient name and Date of Birth
5. Health Plan issued Member ID
6. Date(s) of service
7. All ICD10 diagnosis code(s) present upon visit
8. Revenue, CPT, HCPCS code for service or item provided
9. Billed charges
10. Place of service or UB04 bill type code
11. Provider Tax ID number
12. Provider NPI number
13. Rendering provider name and state license number

Claims that do not meet these requirements may be returned to the provider with an indication of the missing or incomplete information required for processing.

PHC California will process only valid electronic claims submitted in the standard ANSI X12 837 format and containing all essential data elements required for adjudication. Claims that do not meet the required format specifications may be 'rejected' at the clearinghouse level due to improper billing.

A rejection does not constitute an organizational determination or denial; rather, it indicates that the claim did not meet the minimum acceptance criteria and must be corrected and resubmitted. Claims that pass the Clearinghouse but lack other required elements (e.g., modifiers, occurrence codes, condition codes) may be denied after acceptance during adjudication.

Only current standard procedural terminology is acceptable for claim submissions. This includes the following coding systems:

- Current Procedural Terminology (CPT)
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnostic coding
- Healthcare Common Procedure Coding System (HCPCS)

CMS-1500 paper claim submissions must be submitted using form OMB-0938-0999 (08-05), as indicated in the footer of the document. PHC California accepts the revised CMS-1500 and UB-04 claim forms printed in Flint OCR Red, J6983 (or an exact match) ink.

8.3 Claims Documentation

To ensure timely and compliant claim processing, PHC California requires submission of all applicable supporting documentation with each claim. Required documentation varies based on the type of service rendered, the claim format (CMS-1500 or UB-04), and the requirements outlined by DHCS and Medi-Cal provider manuals.

The following documents must be submitted with the claim, as applicable:

Documentation	Applies to
Other coverage Explanation of Benefits (EOB)	All Providers
Dialysis Treatment logs	Dialysis Providers
Doctor's orders, nursing/therapy notes	Home Health Agencies
Full medical record including discharge summary	Inpatient Hospital
Consult, procedures report	Physician

Emergency room report	Emergency Medicine Physicians
Operative report	Surgeon
Minimum Data Set (MDS) Assessment	Skilled Nursing Facility

Billing Providers are responsible for ensuring documentation is complete and available upon request. Incomplete documentation may result in claim denial or delay.
For Inpatient UB-04 claims submission, the following fields and data elements are required:

- Patient name, identification number, and date of birth.
- If subscriber is different from patient, also include subscriber name and identification number
- Provider name, address and NPI
- Bill Type– Box 4
- Tax identification number (TIN) – Box 5)
- Provider's Medi-Cal identification number – Box 51
- Accommodation codes (Revenue Codes)
- Attending provider name and Medi-Cal identification number/State License number – Box 76–77, 82
- Date(s) of Service – Box 6, 45
- Admit Type - Boxes 14–15 / Box 1
- Discharge Status – Box 17 / 22
- Principal and Additional ICD-10 Diagnosis Codes – Boxes 67–72
- Principal and Other Procedure Codes with Dates – Boxes 74–75 / 80–81
- Authorization Number (if applicable) – Box 63

Note: Submission of these data elements in the proper format is required to meet CMS, DHCS, and HIPAA standards for claims adjudication. Providers should ensure coding accuracy and completeness to avoid processing delays.

8.4 Standard Code Sets

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All providers are required to submit claims

and encounters using current HIPPA compliant codes, which include the standard CMS codes for ICD-10, CPT, HCPCS, NDC, and CDT, as appropriate.

8.5 Claim Receipt Verification

Providers may verify claim receipt by contacting the PHC California Claims Department using the contact methods below:

Attention: PHC California
Claims Department
(888) 662-0626
Claims@positivehealthcare.org

Important: Providers must ensure that all transmissions containing Protected Health Information (PHI) are sent through secure, HIPAA-compliant channels. Unsecured transmission of PHI is strictly prohibited.

To support regulatory compliance, providers are strongly encouraged to submit claims electronically and to obtain a 227 CA Health Care Claim Acknowledgment (277 Claim Acknowledgment) acknowledgments or clearinghouse reports for tracking and verification purposes.

PHC California does not issue separate claims receipt confirmations. The official received date is recorded as the internal claim intake timestamp within PHC California's system.

In accordance with DHCS and DMHC guidelines, if a provider disputes whether a claim was received, supporting documentation (e.g., proof of timely submission, clearinghouse transmission reports, or acknowledgment files) may be required.

8.6 Provider Disputes

A Provider Dispute is defined as a written request submitted by a provider or their authorized representative that:

- Requests reconsideration of a claim that has been denied, adjusted or contested.
- Disputes a request for reimbursement due to an alleged overpayment.
- Seeks resolution of a billing or contractual issue not involving member care.

All provider disputes must be submitted using the PHC California Claim Dispute Submission Form, which is available at: **Provider Claims Dispute Submission Form**.

Timeframe to File a Dispute:

Providers must submit a Claim Dispute Submission Form withing three-hundred and sixty-five (365) calendar days from the date of the disputed action (e.g. date of denial, contest, adjustment, or overpayment request). The written dispute must include:

- Provider name, NPI, Tax ID, and contact information
- Member name and ID
- Claim number and date(s) of service
- Detailed explanation for the dispute
- Copy of the original claim
- Copy of the Remittance Advice (EOB/RA)
- Relevant clinical documentation, if applicable

Acknowledgment and Processing Timelines

PHC California will acknowledge receipt of a provider dispute within **fifteen (15) working days** for paper submissions and within **two (2) working days** for electronic submissions. If additional documentation is required, PHC California will request it within **forty-five (45) working days** of receipt of the dispute.

Upon written notification, the provider has **thirty (30) working days** to submit any additional documentation. If the requested information is not received within this timeframe, PHC California will close the dispute. A written determination will be issued within **forty-five (45) working days** of receipt of a complete dispute file.

In the event the Health Plan denies a claim because it was filed beyond the claim-filing deadline, the plan accepts and adjudicates the claim upon provider's submission of a provider dispute and the demonstration of good cause for the delay.

8.7 Submission of Provider Inquiry Requests

Where to Submit Paper Disputes:

Note: Electronic submission of disputes is strongly encouraged for faster processing.

Mailing Address:

Attn: Claims Disputes
PHC California
P.O. Box 46160
Los Angeles, CA 90046

For Additional Assistance:

- **Phone:** (888) 662-0626
- **Email:** claims@positivehealthcare.org *(Ensure all PHI is transmitted securely.)*

The **Claim Dispute Submission Form** can be found in the exhibits section at the end of this chapter.

Contracted provider disputes involving issues of medical necessity or utilization review shall have the right to a secondary level of appeal, provided the appeal is submitted **within sixty (60) working days** from the date of the most recent determination.

8.8 Prohibition on Billing Plan Members

A provider, or any of its agents, trustees, assignees, or subcontractors rendering covered medical services to PHC California Plan Members, cannot bill, charge, collect, or request a deposit or surcharge from the member; nor shall they seek reimbursement or pursue legal action against the member (or any individual acting on the member's behalf) for any amounts owed by PHC California. This prohibition is mandated by California Health and Safety Code § 1379 and Welfare and Institutions Code § 14019.4, and it applies to all Medi-Cal managed care enrollees.

Coverage of Emergency and Follow-Up Care for Rape and Sexual Assault

In accordance with California Health and Safety Code §1367.37, Medi-Cal managed care plans are to cover emergency room medical care and medically necessary follow-up treatment related to a rape or sexual assault without imposing any cost sharing or prior authorization for the **first nine months after the enrollee initiates treatment**.

Rape/Sexual Assault is defined as unwanted sexual acts accomplished under the circumstances described in California Penal Code sections 261, 261.6, 263, 263.1, 286, 287, and 288.7, including but not limited to:

- When the victim is incapable of giving legal consent, or
- When the act is accomplished against a person's will by means of force, violence, duress, menace or fear of immediate harm

PHC California will ensure that enrollees are not required to obtain a referral or authorization prior to receiving these services including follow-up care.

Follow-up health care treatment, specifically for the purposes of compliance with §1367.37, is defined as treatment for rape/sexual assault including medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault. This includes, but is not limited to:

- Behavioral health services
- Sexually transmitted infection (STI) testing and treatment
- Pregnancy testing
- HIV preventive treatment
- Other services medically necessary to address the consequences of the assault

If PHC California receives notice of any attempt to bill or impose a surcharge on a Plan Member, the Plan reserves the right to take appropriate action, including termination of the provider agreement for cause.

Providers are contractually obligated to accept PHC California's payment in full for covered services, except for applicable Medi-Cal approved member cost-sharing obligations, such as:

- Copayments (if applicable under Medi-Cal policy)
- Share of Cost (for members with SOC eligibility)

Prohibited Member Billing Practices

Providers may **not** bill PHC California members under **any circumstances** for the following:

- **Balance billing**: The difference between the provider's billed charges and PHC California's contracted reimbursement rate.
- **Timely filing denials**: Services denied due to the provider's failure to submit claims within the required timeframe.
- **Missing information denials**: Covered services that are returned or denied due to incomplete or missing claim information.
- **Lack of prior authorization**: Services denied for failure to obtain prior authorization when such authorization was required and not secured by the provider.

- **Services deemed not medically necessary by the Plan**, **unless** the provider complied with **Assembly Bill (AB) 72** by obtaining:
    - **Informed written consent from the member** prior to rendering the service.

Failure to comply with this provision may result in corrective action, up to and including termination of the provider agreement for cause.

8.9 Overpayment of Claims

If PHC California determines that a provider has received an overpayment, the Health Plan will issue a written notice to the provider **within three hundred sixty-five (365) calendar days** from the date the overpayment was made. The written notice will include the following details:

- Member name and PHC California ID number
- Date(s) of service
- Claim number
- Total payment amount and the overpaid amount
- A detailed explanation of the reason for the overpayment

Provider Dispute of Overpayment Determination

Providers have **thirty (30) working days** from the date of the overpayment notice to submit a **written dispute** if they disagree with the overpayment determination. Once submitted, the overpayment notice is treated as a **Provider Dispute** and is subject to the applicable procedures and timeframes outlined in **Section 8.6 – Provider Disputes**.

If no dispute is received within the allowable timeframe, PHC California reserves the right to recover the overpaid amount either by offsetting it against future provider payments or by requesting direct reimbursement.

Note: Overpayments identified as resulting from fraud, waste, or abuse (FWA) are not subject to the **three-hundred and sixty-five (365) calendar day** recovery limitation and may be recovered at any time, in accordance with applicable state and federal laws

8.10 Long Term Care Share of Cost

Long Term Care (LTC) facilities must submit claims consistent with the Medi-Cal guidelines for Share of Cost (SOC) outlined in the Medi-Cal LTC Provider Manual. LTC facilities must perform an eligibility verification transaction every month for each Medi-Cal recipient residing in the facility. The eligibility

verification transaction shows how much SOC a recipient must pay for the month, if any. If a recipient has not spent any of the SOC in the month, the facility bills the recipient for the entire SOC and subtracts the SOC payment collected or the amount of the obligated payment from the claim amount submitted to PHC California.

As a result of the Johnson v. Rank lawsuit, Medi-Cal Members can elect to use SOC funds to pay for necessary, non-covered, medical or remedial care services, supplies, equipment, and drugs (medical services) that are prescribed by a physician and part of the plan of care authorized by the enrollee's attending physician. The physician's prescriptions for SOC expenditures must be maintained in the enrollee's medical record. If an enrollee has spent part of the SOC on non-covered medical or remedial services or items, the facility should subtract those amounts from the recipient's SOC and bill the enrollee in an amount equal to the enrollee's remaining SOC.

For more information about LTC SOC, please refer to the Medi-Cal LTC Provider Manual, available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual.

8.11 Timely Claims Processing

PHC California will process and pay claims in accordance with the timeframes established in the provider agreement, applicable California regulations, and requirements set forth by the Department of Managed Health Care (DMHC).

The Plan adheres to the following standards:

- **Pay complete claims within thirty (30) calendar days** of receipt.

8.12 Coordination of Benefits (COB)

PHC California assumes liability for payment of authorized claims **only after** all other liable third parties have been billed and their payment obligations have been fully exhausted or denied. Providers must first bill all applicable primary payers, including **private insurance carriers, Medicare,** and other third-party payers, **prior to submitting the claim to PHC California**.

When submitting claims to PHC California, providers must include **documentation of third-party billing**, such as:

- An **Explanation of Benefits (EOB)**
- A **Remittance Advice**
- A **Denial Notice**

Exceptions – Proof of third-party billing is not required for the following scenarios:

- Services provided to members with Other Health Coverage (OHC) codes **A, M, X, Y, or Z**
- Services defined by DHCS as **prenatal** or **preventive pediatric services**
- **Child support enforcement cases**
- **Emergency services** rendered when the member had no other coverage at the time of service

Providers must adhere to all **DHCS Coordination of Benefits (COB) policies**, including **timely filing requirements** as outlined in applicable **All Plan Letters (APLs)** and PHC California's claims processing guidelines.

Failure to comply with COB requirements may result in claim denials or overpayment recoveries.

8.13 Third-Party Tort Liability

PHC California and its contracted providers must comply with all **Department of Health Care Services (DHCS) third-party liability (TPL) requirements**, as outlined in applicable **All Plan Letters (APLs)** and **State regulations**, to protect DHCS lien rights and ensure proper claims recovery processes.

PHC California is responsible for identifying and notifying DHCS **within ten (10) calendar days** of discovering any case in which a member's legal action involving **third-party tort or Workers' Compensation liability** may result in:

- The **recovery of funds by the member**, or
- The **recovery of funds subject to a DHCS lien**.

Notification of Third-Party Tort Liability Cases

PHC California must be notified **in writing** of all **potential and confirmed third-party tort liability cases** involving a PHC California member. The written notification must include the following information:

- Member name
- Member identification number and Medi-Cal number
- Date of birth

- Provider name and address
- Date(s) of Service
- ICD10 code and/or description of injury
- CPT code and description of service(s) rendered
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for denial

Subpoena and Records Request Notification

Any requests received via subpoena from attorneys, insurers, or members for **billing records or other related documentation** must be **reported to PHC California**. Providers are required to **forward copies of both the request and any response** issued to the requesting party.

All notifications and documentation should be sent to the following address:

Attention: PHC California
Third Party Liability
P.O. Box 46160
Los Angeles, CA 90046

All claims for services rendered in relation to a third-party tort liability case should be submitted for processing as described in the "Claims Submission" section of this manual. The claims will follow normal processing guidelines.

8.14 Claims Auditing: Fee-For-Service Providers

To verify the accuracy of fee-for-service provider billings, a PHC California may conduct random and targeted provider audits, in accordance with DHCS guidelines and All Plan Letters (APLs).

A sample of paid claims will be selected and verified against the member's medical records maintained by the provider. The audit may be conducted onsite at the provider's location, remotely at PHC California's offices, or through electronic medical record review.

If the billing substantially differs from the documentation in the medical record, the findings will be referred to the Claims Manager and the Compliance Department for further review and/or evaluation for potential fraud, waste, or abuse. When appropriate, PHC California will report such

findings to the Department of Health Care Services (DHCS) and other regulatory agencies, as required by law.

PHC California and its contracted providers must comply with all applicable auditing requirements established by the Department of Health Care Services (DHCS) and must cooperate fully during the audit process. Failure to comply may result in claim adjustments, overpayment recoupments, administrative sanctions, or termination of the provider agreement.

8.15 Encounter Reporting (Capitated Providers)

The collection of encounter data is vital to PHC California. Encounter data provides the plan with information regarding all services provided to our membership. Encounter data serves several critical needs. It provides:

- Information on the utilization of services
- Information for use in HEDIS and other quality management studies
- Information that fulfills DHCS and other state and federal regulatory reporting requirements

DHCS has implemented standards for the consistent and timely submission of Medi-Cal encounter data. PHC California is required to submit encounter information to DHCS within **ninety (90) calendar days** following the date of service. To meet this requirement, providers must submit this information to PHC California **no later than sixty (60) calendar days** from date services were rendered. This allows PHC California **thirty (30) days** to process the information prior to submission to DHCS.

Failure to comply with encounter data submission timelines may result in findings of provider non-compliance and may trigger corrective action plans and other remedies as outlined in the provider agreement.

8.16 Encounter Data Policy

PHC California requires all Providers to submit encounter data reflecting the care and services provided to our members. This policy applies to all contracted capitated providers, including hospitals. Primary Care Practitioners (PCPs), and other applicable provider types.

Encounter data must reflect all services provided by ancillary personnel that are under the direction of the PCP, including any specialists or subcontracted providers delivering care and services to PHC California members as defined in their contract with PHC California.

8.17 Encounter Data Procedure

Single encounter is defined as all services performed by a single provider on a single date of service for an individual member.

The following guidelines are provided to assist our providers with submission of complete encounter data:

- Reporting of services must be done on a per member, per visit basis.
- A reporting of all services rendered by date must be submitted to PHC California.
- Encounter Data must include all standard data elements required under Medi-Cal Fee-For Service (FFS) program, including valid diagnosis and procedure codes, rendering provider identifiers and place of service.

All encounter data reporting is subject to, and must fully comply with, the Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) reporting requirements, and all other applicable federal and regulatory mandates.

8.18 Important Submission Information

Encounter data for all Medi-Cal capitated services must be submitted using the standard **CMS-1500 form** or in an equivalent **HIPAA-compliant electronic format** (e.g., **837P**).

- **Hard copy encounter data** must be received by PHC California **within sixty (60) calendar days** from the date of service. This ensures that PHC California can meet the **Department of Health Care Services (DHCS)** requirement to submit encounter data **within ninety (90) calendar days** from the date of service.
- **Electronic submission** is **strongly encouraged** to facilitate faster processing and to support compliance with timeliness and data integrity requirements.

Submission Method for Hard Copy Encounter Data:

Fax Number: **(888) 235-9274**

8.19 Sanctions

"Providers found to be non-compliant with encounter data submission requirements may be subject to sanctions, which may include, but are not limited to: ineligibility for the Encounter Incentive Program, suspension of new member enrollment, capitation payment withholds, and/or termination of the capitation agreement.

Section 9: Credentialing & Re-credentialing

9.1 Credentialing

To ensure providers adhere to PHC California credentialing criteria, provider applicants are screened using industry standards, such as those issued by states, Medicare, PHC California and the National Committee on Quality Assurance (NCQA). PHC California confirms provider information through the credentialing process which requires a contract, a signature attesting to application data and attachments, and verification of credentials.

Each provider undergoes an initial assessment and reassessment at least every three years. In addition, PHC California continues to monitor the status of the provider between the 3-year cycles using regulatory reports, complaints and other information received from external resources (i.e. television news, newspaper, community reputation, etc.) All data collected receives a robust review by the PHC California Credentialing Committee made up of peer provider participants. The Credentialing Committee assesses each provider's credentials to ensure they meet PHC California's credentialing criteria.

PHC California's credentialing criteria include but are not limited to the following:

- Signed agreement to participate
- Signed and completed standard or state-mandated application
- State medical license
- Professional liability coverage
- Admitting privileges, if applicable
- Other active licensure such as DEA/CDS, if applicable
- Education and training including board certification, if applicable
- Sanction activity
- History of employment

PHC California participates in the Council for Affordable Quality Healthcare (CAQH) collaborative. CAQH provides the Universal Credentialing DataSource, a standard application source completed once by the practitioner, helping to eliminate redundant requests for the same information from multiple organizations. Providers can submit an application via CAQH at www.caqh.org.

Providers have certain rights during the credentialing and recredentialing process which include the right to:

- **Review information submitted to support credentialing application.** Information from outside sources (i.e. licensing boards, etc.) will be made available for review. Providers may exercise this right by contacting the Credentialing Department at 1.888.726.5411.
- **Correct erroneous information.** When erroneous information is present, providers are contacted in writing by a representative from the Credentialing Department and notified of the discrepancy. Corrections should be submitted to the Credentialing Department in writing within **15 business days** at the location as noted on the request. All responses are recorded with a date of receipt and maintained as part of the provider's credentialing file.
- **Receive the status of their credentialing or recredentialing application, upon request.** Providers should contact the Credentialing Department to inquire about the status of their application. Providers may inquire about the status of their application electronically or verbally. The Credentialing Department responds to verbal inquiries immediately and electronic inquiries within **fifteen (15) business days.**

The Credentialing Department supplies providers with a notification of their rights and keeps signed acknowledgements of these rights on file.

9.2 Delegation of Credentialing

Organizations that are in compliance with state credentialing regulations, NCQA and AAAHC credentialing standards are welcome to apply for delegated status. Following submission and review of related policies and procedures, an on-site visit or desktop audits is made to audit credential files. After the audit, a report is made to the PHC California Credentialing Committee, which makes the final decision about delegation approvals and denials.

If the Provider is a member of a contracted group that is delegated for credentialing, please be aware that the credentialing/re-credentialing accountability guidelines and operational procedures will be relatively unchanged from those described below.

9.3 Provider's Participation in the Process

An applicant, whether being credentialed or re-credentialed, has the burden of producing adequate information for a proper evaluation of experience, background, training, demonstrated ability, and ability to perform as a Provider, without limitation, including physical and mental health status as allowed by law and the burden of resolving any doubts about these or any other qualifications to be a PHC California provider.

Should an application be incomplete in any way, an email or fax will be sent from PHC California requesting the need for information. To keep an application on active status, the provider will be asked to provide the needed information by a specified time. Failure to provide the information within the required time will result in administrative termination from the PHC California network as a non-compliant provider. Note: All Providers must be in good standing with the Medicare and Medi-Cal programs.

Once appointed, subsequent review of credentials for re-credentialing will be performed no less than every **three (3) years**. A re-credentialing application and release form or a CAQH application will be download from the CAQH site will be sent **approximately six (6) months** before your credentialing period is to expire.

9.4 Facility Site Reviews

Facility site reviews are required for PCPs and OB-GYN specialists upon initial credentialing and re-credentialing. A review of office sites that are accessible to PHC California members will be scheduled as soon as the credentialing application is received by the Credentialing Department. A score of ninety percent (90%) or higher is required for submission of a completed application to the Credentials Committee. Cooperation in working with the facility reviewer on resolving any corrective action plans quickly will facilitate a credentialing decision.

9.5 PCP designation

An OB-GYN specialist, or any other kind of specialist requesting designation as a PCP, will be requested to review a scope of services document that requires signed commitment to provide the services required of a PHC California PCP. Also required is documentation of, general medical training or experience, liability insurance coverage for general medicine, hospital privileges in general medicine or an agreement with a PHC California PCP who can admit medical patients, and back- up coverage by a practitioner qualified to treat general medical conditions.

9.6 Verification of Application Information

The Credentialing and Provider Relations Departments, or its agent, will verify at least the following information from primary sources:

- Current, valid license to practice
- Other certifications appropriate to the services offered by the Provider.
- Current, valid Drug Enforcement Administration (DEA) registration or Controlled Dangerous Substances (CDS) certification.
- Board certification or education from highest level of learning, the latter on initial credentialing only.

- Professional liability claims history for the last **seven (7) years** on initial credentialing and **two (2) years**, if applicable, on re-credentialing

9.7 Practitioner Education and Training:

Graduation from the appropriate professional school is verified through the appropriate licensing Board or directly with the educational source. Completion of residency or specialty/sub- specialty training is verified through the appropriate Board Certification body; directly with the specialty/sub-specialty- training program; or through the American Medical Association or American Osteopathic Information Association for physicians.

The following information is verified or attested to from the CPPA or CAQH application:

- Clinical privileges, in good standing, at the hospital designated by the physician as his or her primary admitting facility, as applicable and agreed to in the physician's contract
- Current, adequate malpractice liability coverage according to PHC California's policy (as of 6/99, coverage of one million per occurrence and three million aggregate are required)

The Medical Staff/Credentialing Department will also:

- Identify any disciplinary actions and/or sanctions
- Query the National Practitioner Data Bank

Should any information gathered during the verification process differ substantially from the information provided, the Practitioner will be notified, and the Provider's "rights process" will be initiated. This process is explained on the "Notice to Practitioners of Credentialing Rights/Responsibilities" that accompanies the credentialing/re- credentialing application.

9.8 Credentialing Committee Review

PHC California maintains a Credentialing Committee chaired by the Medical Director and made up of your peers. The Committee is required to meet no less than bi-monthly, or more frequently if needed, to facilitate timely processing of applicant files.

Once the credentials file contains all the necessary information, verifications and facility site review findings, it will be reviewed by the Credentialing Committee. If the Credentialing Committee determines that further information is necessary to evaluate an application, the Credentialing and Provider Relations Departments will request such information on behalf of the Credentialing Committee. The Credentialing Committee may, in its sole discretion, request an in-person interview.

9.9 Credentials Committee Recommendation

The Governing Board receives recommendations to either approve or deny applicants from the Credentialing Committee. Once acknowledged, the Credentialing Committee notifies applicants of its decision. Copies of the credentialing files and application status are available to the providers upon request.

9.10 Corrective Action, Fair Hearing Plan, and Reporting to the Medical Board of California and the National Practitioner Data Bank

Practitioners have a procedural right to appeal in the event that peer review recommendations and actions result in filing a report to the Medical Board of California (MBOC) and the National Practitioner Data Bank (NPDB). The appeal right, the Fair Hearing Process, and the requirement to report to the MBOC and NPDB are described in PHC California Policy & Procedure CR 2.1 and CR 3.1. Copies of these policies and procedures will be mailed as an enclosure to the Credentials Committee letter advising you of initial approval status. Please review and retain these copies in a file.

9.11 Re-credentialing Requirements

In addition to verifying that Providers continue to meet the basic qualification set forth in PHC California Policy and Procedure CR 1, Practitioner/Provider Credentialing and Re-credentialing-Basic Qualifications for Provider Status, the following information will be reviewed as part of the re-credentialing process:

- Results of quality reviews. The Quality Management staff will complete a Provider profile for all Providers, gathering information from reported quality performance issues, utilization management performance, member satisfaction surveys, and non-administrative member services reports. Findings will be sent to the Credentialing and Provider Relations Departments for inclusion in the credentialing profile and for the consideration of the Credentials Committee.
- Utilization management issues. PHC California staff will review each Provider's UM profile for acceptability of performance and for compliance with UM requirements. Findings will be forwarded to the Quality Management Department for inclusion in the Provider re-credentialing profile.
- Satisfaction surveys and Member Grievances/Complaints. Member Services will report quarterly to the Credentialing and Provider Relations Departments each Provider who has been identified through member grievances/complaints and member satisfaction surveys as having deficiencies in the area of customer service.

9.11.1 Current Documentation of DEA and Liability Insurance Coverage

Should a DEA, medical license and/or liability insurance coverage expire at some time prior to

your next re-credentialing date, you will receive a request for updated information for the credentials file. Failure to provide this information within the specified time will result in automatic suspension from the PHC California network. This will not be an on-going process but only done on an "ad-hoc" basis as may be requested from time to time.

As an applicant for credentialing/re-credentialing, you have a right to review non- privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. This does not include the review of information that is privileged, including references or recommendations that are legally protected from disclosure.

You may request to review such information at any time by sending a written request, via fax or letter to:

Medical Staff Office (MSO) and Credentialing
1710 N. La Brea Ave.
Los Angeles, CA 90046
Fax: **(323) 337-9142**

Upon receipt of your request, the Director or their designee will contact you **within three (3) working days** to schedule a date and time to review the information at the PHC California Credentialing Department.

9.12 Notification of Discrepancy

You will be notified in writing, by email, fax or letter, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

9.13 Correction of Erroneous Information

If you believe that erroneous information has been supplied to PHC California by primary sources, you may correct such information by submitting written notification to the Director of Credentialing at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to PHC California within **three (3) working days** of your credentials file review date and/or the date that PHC California notified you of the discrepancy.

Upon receipt of your notification, PHC California will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will

be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter or fax. You will be requested to provide proof of correction by the primary source to Medical Staff/Credentialing Services of PHC California via letter or fax as cited above within ten (10) working days. Subsequently, a second re-verification of primary source information will be performed by PHC California. If, **after ten (10) working days**, primary source information remains inconsistent and in dispute, you will be subject to adverse action up to administrative termination from the PHC California Network.

9.14 Physician Facility Reviews: Facility Site Reviews

The review and certification of Primary Care Practitioner (PCP) sites is a requirement of the California Department of Health Services under Title 22, California Code of Regulations, Section 53230. This section mandates that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified. Additionally, site review and certification is a standard for accreditation set forth by the National Committee for Quality Assurance (NCQA).

A PCP is defined as a General Practitioner; a Family Practitioner; an Internist; an OB/GYN who requests PCP status; or a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services. PHC California will remain the primary responsible party for the facility review activities and monitoring of all Medi-Cal PCP Sites.

PHC California will ensure that facility site reviews are incorporated into the credentialing process and conducted on all PHC California Primary Care Providers (PCPs) and OB/GYNs, in accordance with applicable standards set forth by the Department of Health Care Services (DHCS) and/or the National Committee for Quality Assurance (NCQA).

9.14.1 Medi-Cal Facility Site Review Process

Effective July 1, 2002, the State of California's Health and Human Services Agency Department of Health Services mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) start using the new Full Scope Site Review (FS-SR) and Medical Record Review Tool (MRR). This is found in MMCD Policy Letter 02- 02 (Supersedes MMCD Policy Letter 96-6). To avoid duplication and overlapping of reviews, the managed care plans will have a collaborative procedure to have one managed care plan conduct the review that will be accepted by all managed care plans. This will establish one (1) certified FS-SR and MRR that the participating PCP will need to pass and be eligible with all the Medi-Cal Plans in a given county.

Initial Full Scope Review

All primary care sites serving Medi-Cal managed care members shall undergo an initial site review with attainment of a minimum passing score of 80% on both the site review survey and medical record review survey. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a passing full scope survey within the past **three (3) years**. The initial full scope site review survey can be waived by managed care plan for a pre-contracted physician site if the physician has documented proof that a current full scope survey with a passing score was completed by another managed care plan within the past **three (3) years**.

Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conduction of the next required full scope site survey shall be **three (3) years**. Managed care plans may review sites more frequently per local collaborative decision, or when determined necessary based on monitoring, evaluation or corrective actions plan (CAP) follow- up issues.

Ten (10) medical records shall be reviewed initially for each physician as part of the site review process and every **three (3) years** thereafter. During any medical record survey, reviewers shall have the option to request additional records for review. Sites where documentation of patient care by multiple PCPs occurs in the same record shall be reviewed as a "shared" medical record system. Shared medical records shall be considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of ten (10) records shall be reviewed if two (2) to three (3) PCPs share records, twenty (20) records shall be reviewed for four (4) to six (6) PCPs, and thirty (30) records shall be reviewed for seven (7) or more PCPs.

9.14.2 Scoring

All PHC California OB/GYN/PCP and Pediatricians (PCP's) must maintain an **Exempted** or **Conditional** pass on site review and medical record review. An **Exempted Pass** indicates a score that does not require a Corrective Action Plan. A **Conditional Pass** indicates a score that does require the implementation of a Corrective Action Plan

9.14.3 Facility Site Review

- Exempted: A score of 90-100% without Critical Element Deficiencies
- Conditional: A score of 90-100% with Critical Element Deficiencies or a score of 80 to 89%
- Fail is a score of 79% or below Medical Record Review
- Exempted: A score of 90 to 100%

- Conditional: A score of 80-89%
- Fail is a score of 79% or below Relocation and/or New Site
- PHC California follows the same procedures as for an initial site visit when a PCP relocates or opens a new site

9.14.4 Compliance & Corrective Action Plan (CAP)

- Physicians with an Exempted Pass Score
- All reviewed sites that score 94% and above, without critical elements deficiencies, on the facility review portion do not need to submit a CAP
- All reviewed sites that score 90% on the medical record review portion do not have to submit a CAP

9.14.5 Physicians with a Conditional Pass Score

- Critical Element Deficiencies must have CAP completed and submitted within ten (10) working days of the review
- A score of 80% to 93% on the facility review portion must submit the CAP for the facility review portion of the Site Review. This must be completed and submitted within **thirty (30) days** of the review.
- A score of 80% to 90% on the Medical Record Review portion must submit the CAP for the Medical Record Review Portion of the Site Visit. This must be submitted within **thirty (30) days** of the review being completed and signed.

9.14.6 Physicians with a Failing Score

No new members will be assigned to the provider site until the Critical Element Corrective Action Plan (CAP) has been completed, all deficiencies have been corrected and verified, and the remainder of the review CAP has been submitted and fully accepted. Alternatively, a follow-up site visit must be conducted, and a focused review completed with a passing score.

In accordance with the Department of Health Services, Medical Managed Care Division Policy Letter 02-02, all Medi-Cal managed care plans operating within the county must be notified as required under the Collaboration section of the policy.

9.14.7 CAP Timeline Extension

No timeline extensions are permitted for the completion of Corrective Action Plans (CAPs) related to critical elements.

A Physician may request a definitive, time-specific extension period, not to exceed **ninety (90) calendar days** from the date of the review by writing a specific request letter, stating the exact reasons for the request and submitting the completed portions of the CAP within the **initial thirty (30) daytime periods**.

No extension beyond **ninety (90) days** from the date of the review can be granted by the plan. Any extension beyond **ninety (90) days** requires the approval of the Department of Health Services prior to the extension being granted.

Corrective Action Plan (CAP) Completion Guidelines

Note: An extension for CAP completion beyond ninety (90) days requires that the site be re-surveyed within twelve (12) months of the initial survey, as stated in MMCD Policy Letter 02-02, Corrective Action Plan Section 1F(2).

CAP Completion Instructions

Physicians or their designees are responsible for completing the CAP using the following steps:

1. **Column Two (2):** Check the box to indicate the identified deficiency.
2. **Column Three (3):** Clearly describe the specific deficiency noted during the survey.
3. **Column Four (4):** Document the corrective action taken. Review the column to determine whether a selection or specific action is required. If attachments are needed, they will be indicated in **bold** within this column.
4. **Column Five (5):** Enter the date of completion or implementation. Include any comments related to changes made, then initial the entry.
5. **Column Six (6):** Enter the name of the physician or designee responsible for completing the CAP item.

Once all indicated items have been completed and/or implemented and **Columns Five (5) and Six (6)** have been filled in for all deficiencies, submit the completed CAP as instructed.

9.14.8 Corrective Action Plan (CAP) Submission

At the physician's discretion, any affiliated management company or contracted medical group may be engaged to assist with the completion of the CAP. The CAP must be submitted directly to PHC California.

For physicians reviewed by PHC California, CAPs must be submitted using one of the following methods:

By Fax:
(323) 337-9142

By Mail:
PHC California
Attn: Credentialing Department
1710 N. La Brea Avenue
Los Angeles, CA 90046

9.14.9 Identification of Deficiencies Subsequent to an Initial Site Visit

Any PHC California Department Director or Manager shall concurrently refer concerns regarding member safety and/or quality of care service to Medical Staff/Credentialing Department. Should such a referral be made, the Director of Credentialing, or his/her designee, will be notified.

Member complaints related to physical office site(s) are referred to Provider Relations Department or Member Services Department, and his/her designee, who will investigate the complaint through performing an on-site facility review and follow-up of any identified corrective actions. The Quality Improvement Department will be advised of any adverse findings in order to provide a method of tracking these physicians.

Accusations filed by a Medical/Podiatric Board, against a physician, may be a source for identification of potential site review issues.

Referrals from PHC California Provider Relations Representatives who have concerns specific to a physician(s) site are referred to the Quality Improvement Manager, or his/her designee.

9.14.10 PHC California's Performance of Facility Site Reviews

DHCS conducts oversight audits of PHC California, including its contracted physicians and facilities. These visits may be conducted with or without prior notification by the DHCS. If prior notification is given, the sites selected by the DHCS for oversight reviews will be contacted for scheduling by either the DHCS auditor or PHC California.

PHC California will provide any necessary assistance required by DHCS in conducting their facility oversight evaluations and reviews of the quality of care for services rendered to members.

9.15 Reference Tools

This manual provides information on a variety of topics to assist physicians and their office staff in preparing for the office site visit, including, but not limited to, the following:

- Child Health and Disability Prevention (CHDP) program information
- Comprehensive Perinatal Services Program (CPSP) information
- Informed consent process for sterilization
- Access to care standards
- Sample continuity of care, referrals, consultation, and diagnostic-testing tickler log
- Sample medical record medication sheet
- Preventive care information

Please reference Infection Control Practices and Environmental Safety section identified in this Provider Manual for additional information your office should follow for guidelines and requirements that will be evaluated in the event your office requires a facility site review (FSR) or Physical Accessibility Review Survey (PARS). These sections contain important details that will help you ensure proper practices, processes, and training for you and your staff are available to ensure high quality care & safety for patients, staff and visitors in your office.

Section 10: Provider Services

10.1 Contracting and Provider Relations Department

The Contracting and Provider Relations Department is committed to collaborating with you and your staff to provide education, training, and support to ensure a positive experience in serving PHC California members and working with PHC California. Provider Relations is also available to assist with any questions or concerns related to your participation in the Plan.

The Provider Relations Department acts as the liaison between PHC California Departments and the external provider network to promote positive communication, conduct orientations, facilitate exchange of information, and to seek efficient resolution of provider issues. Please send all requests to your Provider Relations Representative, as your Provider Relations Representative is your primary source of information.

We encourage you to make recommendations and suggestions to better serve our members and to improve the processes within our organization.

10.2 Provider Manual

The Provider Manual is available to all newly contracted providers upon execution of an agreement with PHC California and can be requested by any contracted provider at any time. It is periodically reviewed and updated as content changes. An electronic version of the provider manual is available on our website at: https://www.phc-ca.org/providers/pubs

10.3 Provider Orientations/In-Services

Orientations are conducted by the Provider Relations Representative to educate new providers on plan operations, policies and procedures within ten (30) business days of contracting with PHC California. If, as a new provider, you are unable to schedule your training within the ten (30) day period, as required by DHCS, your training will be scheduled at a more convenient time, but your contract with PHC California will not become effective until your orientation is completed.
As needed, Provider Relations will share training, education, and pertinent required information with providers using a variety of media, including web posting, provider bulletins, newsletters or mailings. This includes dissemination of mandatory trainings such as Diversity, Equity, and Inclusion (DEI) education required by regulatory or contractual obligations. Existing providers may also request additional training by scheduling an in-service with a Provider Relations team member.

Provider Orientations/In-Services includes the review of the following information:

- Administration overview and contact information
- Enrollment & Eligibility, Provider Portal Registration
- Member Benefits
- Utilization Management Processes including Initial Health Appointment (IHA)
- Access and Availability Standards
- Referral Submission, Referral Status, STAT/Urgent Requests
- Claim Submission, Claim Status, Provider Disputes, Provider Grievances
- Provider Relations Contacts and Credentialing
- Health Education
- Provider Notification requirements including but not limited to relevant Provider Bulletins concerning operational and regulatory requirements.

10.4 Provider Rights

Providers who treat PHC California members have the right to:

- Be informed of participating contractual obligations placed on the provider by the Health Plan and the sponsoring government agency.
- File a grievance or complaint about the program and/or any associated functions of the Health Plan.
- An overview of the PHC California and AIDS Healthcare Foundation.
- Contact information for Health Plan departments.
- Give feedback on the program, including participation in any activity soliciting provider input or feedback as to provider satisfaction and/or Plan performance surveys.
- Receive current HIV/AIDS treatment guidelines from nationally accepted sources.
- View applicable assessments and plans of care upon request.
- Member information obtained through the program in the coordination of disease management services for clinical decisions, as applicable.
- Respectful and courteous interactions with Health plan staff.
- Collaboration with other HIV/AIDS primary care providers and specialists who work with the Health Plan for support when interacting with their patients to make decisions about their healthcare.

10.5 Provider Directory

The PHC California Provider Directory is updated monthly. It is available to enrollees in print and though the PHC California website at www.phc-ca.org/provider-find. The directory is solely used as a member handbook referencing participation to primary care physicians, hospitals, specialty care physicians, ancillary providers and vision providers.

All providers are responsible for reviewing their information in the directory and submitting any changes to PHC California's Contracting and Provider Relations Department or via the Provider Information Updates section on the PHC California website www.phc-ca.org/providers/provider-info/

Providers may also review information on the PHC California website at www.phc-ca.org/provider-find. PHC California is committed to ensuring the integrity of the directory. The Provider Data Management and/or Contracting and Provider Relations Department will periodically contact your office to validate your information listed in the Provider Directory. Contracted providers are required to respond to the Plan's request for verification of provider directory information in accordance with Section 1367.27 of the California Health and Safety Code.

Please see detailed Provider Directory requirements outlined in the attached reference document: https://positivehealthcare.net/wp-content/uploads/2021/10/Provider-Bulletin-SB-137-CA-Provider-Directory.pdf

10.6 Gender-Affirming Care

In accordance with California's Transgender, Gender Diverse, and Intersex (TGI) Inclusive Care Act, and to help TGI patients find appropriate providers more easily, PHC California updates the Provider Directory to indicate which providers have affirmed that they offer and have provided gender-affirming services. Services may include primary care, behavioral health, hormone therapy, and gender-affirming surgical services, consistent with applicable standards of care. To have your practice identified in the Provider Directory as a provider of gender-affirming services, please complete the Gender Affirming Services Attestation Form available on the PHC California website at www.phc-ca.org/providers/provider-info/

10.7 Provider Validation Activities

In addition to routine provider data verification, DHCS requires health plans to conduct additional validation activities to ensure the accuracy and completeness of provider information. PHC California makes every effort to ensure these activities are minimally disruptive and convenient for providers.

These activities may include, but are not limited to:

- Collection of required practice-level data as mandated by the State
- Evaluation of provider access and availability for both routine and urgent appointments
- Assessment of member wait times and call center responsiveness, including speed of answer for provider office phones.

To support compliance with DHCS requirements, providers may be contacted via phone, asked to complete surveys, or schedule onsite inspections. These **facility site reviews** assess compliance with **Americans with Disabilities Act (ADA)** accessibility standards and confirm that members can safely and comfortably receive care at the provider's location.

PHC California is committed to conducting these validations as efficiently and respectfully as possible.

10.8 Specialty Provider Network Oversight

PHC California monitors the specialty network to identify deficiencies in the provider network service areas. All monitoring efforts are made to ensure the Health Plan's specialist network continues to meet Plans and regulatory network adequacy standards and ensure PHC California members have access to all required specialties. If you find that specialists you work with regularly are not in the PHC California network, we encourage you to contact the Provider Relations department to let us know or have referral specialists call us so we can discuss contracting. It is our commitment to have the best referral network available to our members and providers.

10.9 Provider Network Changes

Please reference Health and Safety Code section 1367.27 Annual Notice for additional specifics regarding the areas outlined in this section. All provider changes should be submitted in writing to PHC California's Provider Relations Department sixty (60) days in advance for the following:

- Terminations
- Office relocations
- Leave of absence or vacation
- Tax Identification Number (TIN) or other billing change.

10.10 Provider Terminations

Providers must send written notification **ninety (90)-days** in advance of a termination notification. Termination dates are determined by your contract.

For continuity of care, PHC California reserves the right to obligate the provider to provide medical services for existing members until the effective date of termination according to the terms of your contract with PHC California.

PHC California is responsible for transitioning member care for all terminated providers.

10.11 Office Relocations

PCP's changing office locations require a Facility Site Review. Once the site is approved, the provider's address is updated, and members are transferred to the existing site. If the PCP moves outside of the former office's geographic area, PHC California will reassign the members to a new PCP within Department of Healthcare Services (DHCS) access standards.

Written notification must also be submitted to PHC California's Provider Relations Department for all telephone and fax number changes.

10.12 Provider Leave of Absence or Vacation

Please reference Health and Safety Code section 1367.27, Annual Notice for additional specifics regarding the areas outlined in this section. When a provider is requesting a leave of absence or has a planned vacation, a provider must state the exact start and end dates of your absence and when clients can expect your return. A provider must provide the name and contact details (email and/or phone) of a colleague who can assist clients with urgent matters during your absence. If you have limited or no access to email, please set realistic expectations for response times. Finally, express your appreciation for their understanding and assure them that you will respond to their messages as soon as possible upon your return.

Section 11: Delegated Entities

All participating providers and delegated entities are required to comply with all applicable federal, state, and contractual requirements. Delegated entities are subject to routine audits by PHC California to ensure ongoing compliance with these obligations.

If you would like a copy of all applicable standards, please contact our Provider Relations Department at capr@ahf.org for further assistance.

Credentialing and re-credentialing standards are outlined in Section 9 (Credentialing and Re-credentialing).

Section 12: Grievances & Appeals

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

- Provider Appeal (related to an authorization determination)
- Provider Disputes-AB 1455 (related to provider claims appeals)
- Member Appeals (related to an authorization determination)
- Member Grievances (complaints related to dissatisfaction with care or service)

12.1 Provider Grievances or Complaints - the Appeal Process

A provider grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. There are two (2) types of appeals:

- Appeals regarding non-payment
- Appeals regarding claims processing also known as provider disputes (please refer to the Claims Section above for further information concerning PHC California's Provider Dispute process).

A provider may submit an appeal concerning the modification or denial of a requested service, the payment processing, or non-payment of a claim by the Plan.

PHC California complies with the requirements specified in Section 56262, Title 22 of the CCR, and the DMHC Assembly Bill 1455 Provider Disputes/Claims Appeals.

12.2 Provider Appeals Regarding Modifications or Denial of a Service Request.

The provider appeal process offers recourse for practitioners who are dissatisfied with a denial or decision form PHC California. There are two (2) types of appeals: provider disputes and appeals for prior authorization denials.

The initial appeal is considered to be a First Level appeal. If the disputed denial is upheld during the First Level appeal, a final or Second Level appeal may be requested from the Department of Health Services, State of California.

PHC California does not take any - punitive or retaliatory action against - providers who file or support a member's appeal regarding a denial or delay of services.

12.3 Member Hold Harmless Indemnification (Balance Billing Prohibition)

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

12.4 Member Appeals and Grievances

Health plan members (also known as enrollees) or their authorized representatives have the right to file a grievance (also called a complaint) or an appeal, depending on the nature of their concern with the health plan.

A **grievance (complaint)** is an expression of dissatisfaction with any aspect of care or service, such as provider behavior, access to care, customer service, or facility issues.

An **appeal** is a formal request to review and change a decision made by the health plan to deny, reduce, delay, or stop a health care service or benefit.

Authorized Representatives, including Providers, have the right to access the enrollee's medical records and file an appeal or grievance on the enrollee's behalf with written permission from the enrollee. Enrollees or authorized representatives can file a grievance/complaint or appeal with PHC California in any of the following ways:

- Over the phone
- In writing
- Fax

If the health problem is urgent, if you already filed a complaint with PHC California and are not satisfied with the decision, or it has been more than thirty (30) days since you filed a complaint with PHC California you may submit an Independent Medical Review/Complaint Form with DMHC.

12.4.1 How to File an Appeal or Grievance

If the Member or Provider on behalf of a member is dissatisfied with an adverse authorization decision or has a grievance, he or she may initiate the appeal/grievance process by telephone, fax or in writing:

Attention: PHC California
Member Services
P.O. Box 46160
Los Angeles, CA 90046
Phone: **(800) 263-0067**
Fax: **(888) 235-8552**

Enrollees, their authorized representatives, or providers acting on their behalf may file an appeal of an Adverse Benefit Determination with PHC California within sixty (60) calendar days from the date of the Notice of Action (NOA) issued by the Health Plan.
The Health Plan continues to furnish disputed services during the appeal process in accordance with regulatory and contractual requirements.

Enrollees who are unhappy with PHC California for any other reason can file a grievance at any time.

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

PHC California has **thirty (30) days** to process a standard appeal. In some cases, members have the right to an expedited, **seventy-two (72) hour** appeal. Members can get a faster, expedited appeal if the member's health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to **thirty (30) days**. If a member requests an expedited appeal, the health plan will evaluate the member's request and medical condition to determine if the appeal qualifies as an expedited, **seventy-two (72) hour** appeal. If not, the appeal will be processed within the standard **thirty (30) days**. The member and provider will be notified of the downgrade status to a standard appeal process and UM will provide both parties with their rights in regard to adverse benefit determinations.

12.4.3 Standard (30-day) and Expedited (72-hour) Grievance Processes

PHC California will provide the member or representative with written notification acknowledging the member grievance within **five (5) working days** of its receipt unless the issue submitted can be resolved in less than **twenty-four (24) hours**. The member or representative will be informed in writing of the proposed resolution or outcome of the grievance within **thirty (30) days**. In instances where an imminent and serious threat of health of a beneficiary, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, yet are "urgent" or "expedited" in nature have a timeframe for resolution in **seventy-two (72)** hours. Grievances can be filed any time from the date of the incident subject to the beneficiary's dissatisfaction.

It is important to note that a member grievance may be a potential quality issue or service issue and PCP's as well as their office staff, should be ready to assist a member with any necessary information. You must have a grievance form in your office conveniently located for your members. If you need to order grievance forms, please contact Member Services at **(800) 263-0067**.

Member complaints may include, but are not limited to:

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

PHC California will investigate member grievances, attempt to resolve the concerns, and take action as appropriate. Resolutions and findings are considered confidential and are privileged under California law. A member must not be discriminated/retaliated against because he/she has filed a member grievance.

12.5 Independent Medical Review (IMR) and Consumer Complaints

If your patient has a health problem that is urgent, if you already filed a complaint with PHC California and are not satisfied with the decision, or it has been more than thirty (30) days since you filed a complaint with PHC California, the patient may submit an Independent Medical Review/Complaint Form with DMHC. (Please refer to: http://www.dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaintForm.aspx)

In most circumstances, the enrollee or representative is required to file a grievance regarding each issue/request with your health plan and participate in the process for thirty (30) days before submitting a complaint to the DMHC. Exceptions to this requirement include when there is an immediate threat to the enrollee's health or the request was denied as experimental/investigational. In either of these instances, you may seek immediate assistance from the DMHC.

An Independent Medical Review (IMR) is a review of the patient's case by independent doctors who are not part of PHC California. The patient has a good chance of receiving the service or treatment he or she needs by requesting an IMR. If the IMR is decided in the patient's favor, PHC California must authorize the service or treatment the patient requested. IMR's are free to enrollees.

Consumer complaints may also be submitted using the same form. Consumer Complaints include issues such as:

- Balance billing
- Billing for services that PHC California states is not a covered benefit
- Disputes on the amount paid on a claim
- A co-pay dispute
- Cancellation of the enrollee's coverage
- A complaint about the plan or provider's attitude or quality of care

If the person who is submitting the Independent Medical Review/Complaint Form needs help, please call the DMHC Help Center at 1(888) 466-2219 or visit https://wpso.dmhc.ca.gov/contactform/.

12.5.1 Urgent Cases for Independent Medical Review

The IMR process allows for exceptions to be made when there is a serious or imminent threat to the patient's health. CIC Section 10169.3(c) states that if the "insured's provider [doctor/medical professional] or the California Department of Insurance (CDI) certifies in writing that an imminent and serious threat to the health of the insured may exist, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured," the IMR organization must make its determination within three days of receiving the proper case information. Moreover, your insurance company must deliver the necessary information and documents to the IMR organization within **twenty-four (24) hours** of approval from the CDI of your IMR request.

When the CDI reviews your request for an IMR, the Department may waive the requirement that complainant first go through PHC California's appeals/grievance process when an extraordinary or compelling case exists. The Insurance Commissioner may make exceptions based on the criteria listed in CIC Section 10169.3(c) above and based on the Insurance Commissioner finding that you have acted reasonably in the dispute with your insurance company.

12.6 State Fair Hearing

In addition to the grievance processes offered you have the right to request a Fair Hearing from the State of California. Enrollees must exhaust PHC California's internal Appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a State Hearing. If PHC California fails to adhere to the required timeframe when resolving the Appeal, the enrollee is deemed to have exhausted PHC California's internal Appeal process and may request a State Hearing.

You may request a State Fair Hearing by contacting the California Department of Social Services (CDSS) within **one hundred and twenty (120) days** of the Notice of Appeal Resolution. You may write or call CDSS, toll-free, at any time during the grievance process, at the following address and telephone number:

California Department of Social Services State Hearings Division
744 P Street, MS 9-17-433
Sacramento, CA 95814
1 (800) 743-8525 (Voice) or **1 (800) 952-8349 (TDD)** or **Fax 1 (833) 281-0903**

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

Enrollees and/or enrollees' authorized representatives have the right to request continuation of benefits during the State Fair Hearing process. Upon request, the Health Plan will not discontinue services for which a State Fair Hearing has been filed until the appeal process has concluded. However, if the Utilization Management Department's initial decision to deny, discontinue or reduce disputed service is upheld, the enrollee may be financially responsible for the cost of the disputed services provided during the external appeal process.

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

12.6.1 Expedited State Fair Hearing

A member may request an Expedited State Hearing by calling, writing, faxing California Department of Social Services State Hearings Division. Expedited Hearing Unit, —744 P Street, MS 9-17-433, Sacramento, CA 95814, Fax: **(833) 281-0903.** For a verbal request, call the California Department of Social Services Public Inquiry and Response at **(800) 743-8525-**

(Voice) or **(800) 952-8349 (TDD)**. PHC California or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function.

When the Expedited Hearing Unit determines that your appeal satisfies the expedited criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Fair Hearing as described above.

12.7 Department of Health Services (DHCS) Assistance

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

12.7.1 State Regulations Available

State regulations, including those covering state hearings, are available at the local office of the county welfare department.

12.8 Authorized Representative

Members can represent themselves at the state hearing. They can also be represented by a friend, attorney, or any other person, but are expected to arrange for the representative themselves. Members can get help in locating free legal assistance by calling the toll-free number of Public Inquiry Response **Unit (800) 952-5253**, **(Voice) (800) 952-8349 (TDD)**.

12.9 Additional Information

If you have any questions regarding the member grievance process, or if you would like a copy of the Membership Services Guide please call Member Services at **(800) 263-0067, TTY/TDD 711.**

Section 13: Health Education

As providers, you are in the best position to support the many health education needs of PHC California members during their medical visits. Your role as a trusted and credible source of information makes you the most effective educator for your patients.

13.1 DHCS Health Education Contract Requirements for Managed Medi-Cal Members

- **Member Education:** Topics include preventive and primary care, complementary and alternative care, health education services, and community resources
- **Risk-Reduction & Health Promotion:** Areas of focus include tobacco use and cessation, alcohol and drug use, injury prevention, dental health, sexually transmitted diseases (STDs), tuberculosis, HIV, family planning, nutrition, and physical activity
- **Patient Education:** Includes chronic and high-risk conditions such as asthma, diabetes, hypertension, pregnancy, and obesity.

All education must be documented in the member's medical record. This documentation supports continuity of care, allowing all care team members to reinforce health education messages and encourage behavior change over time. Accurate and timely documentation is also essential for demonstrating compliance during audits conducted by regulatory agencies.

Health Education supports all contracted Providers by offering the following:

- Written materials available in multiple languages
- Health promotion campaigns
- Direct mailings to members
- Referrals from the Medical Care Management Department to address identified health education needs, either on behalf of a provider or for an individual member
- HIV Medication Adherence Program (all ages)

13.2 Health Education Resources and Written Patient Education Materials

PHC California can help you access educational materials through your local Child Health and Disability Prevention (CHDP) Program and other public health resources in your community. In addition, PHC California develops and curates patient education materials that are culturally and linguistically appropriate for diverse member populations and cover key health topics. The most effective setting for members to receive written materials is during a visit with their primary care

practitioner (PCP), accompanied by a brief discussion to support understanding and engagement. To request materials for your PHC California members, please contact the Health Education Department. All materials are written at or below a sixth-grade reading level to support health literacy and member comprehension.

13.3 PCP Responsibilities for Health Education

DHCS and PHC California require that all Medi-Cal Managed Care contract requirements are met for Health Education.

13.3.1 Individual Health Education

All Providers of managed Medi-Cal members must administer an individual health education behavioral assessment. This must be done with new patients at their Initial Health Assessment within one hundred and twenty (120) calendar days of enrollment and with existing members at their next scheduled non-acute care visit (but no later than their next scheduled health screening visit). Primary Care Physicians must complete the Assessment annually except in years when the assessment is re-administered.

13.3.2 Individual Patient Education and Counseling

Providers, as the most credible source of health information for members, should deliver education tailored to each individual's needs during every visit. All education provided must be documented in the member's medical record to support continuity of care and reinforce learning over time.

13.4 Appropriate and Timely Health Education Referrals

Members requiring additional education support should be referred to PHC California's Care Management Department. All referrals for health education should be documented in the medical record. All documentation provided by Care Management following the interventions should be filed in the member's medical record. Providers should follow up with the member on educational referrals at the next scheduled visit and should reinforce key concepts.

13.5 Print Materials

All written material provided to PHC California members must be written at the sixth (6th) grade reading level or below. Materials should also be culturally sensitive and appropriate for the member. For support in meeting these requirements, please contact the Care Management Department.

13.6 Tobacco Cessation

PHC California offers a tobacco cessation program, *Quit for Life*, that will help members overcome both the physical and psychological addiction to tobacco.

Primary care providers (PCPs) should screen and educate members regarding tobacco cessation by:

- Informing members about the health risks associated with tobacco use
- Helping members anticipate and avoid triggers
- Providing basic education on tobacco addiction and evidence-based quitting strategies
- Encouraging open dialogue about the desire to quit
- Actively encouraging members to begin the quitting process

PCPs should refer members who smoke or desire to quit using tobacco to contact the *Quit for Life* Program:

Call: 1-866-784-8454 (1-866-QUIT-4-LIFE)
Join online: www.quitnow.net/ahf

Instruct the member to tell the operator they are a PHC California member. For more information, members can contact Member Services at **(800) 263-0067**, 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

13.7 Five Wishes (Advance Care Planning) Workshop

PHC California provides an ongoing class, Five Wishes, to all members about advance care planning. The Five Wishes Workshops provide our clients with a safe and informative small group setting to ensure that the documents are completed correctly and completely. Please contact Provider Relations at **(888) 726-5411**, Monday through Friday, 8:30 a.m. to 5:30 p.m. for more information.

Section 14: Cultural & Linguistic Services

PHC California is committed to being respectful of and responsive to the cultural and linguistic needs of our members. The United States Department of Health & Human Services, Office of Minority Health, has issued national culturally and linguistically appropriate services (CLAS) standards. PHC California is committed to a continuous effort to perform according to those standards.

PHC California uses Language Line for interpreter services as needed to communicate with members who have limited English proficiency. Providers are expected to have access to interpreter services to accommodate their non-English speaking patients. If you do not have access to interpreter services to accommodate a non-English speaking patient who is a member of the plan, PHC California will provide such access. Please contact Member Services at **(800) 263-0067** to request assistance.

Providers may request a "Self-Assessment Checklist for Personnel Providing Primary Health Care Services," from PHC California to assess their cultural competency in the delivery of health care services. The checklist is also available online: http://nccc.georgetown.edu/documents/Checklist%20PHC.pdf

Cultural competency training modules for clinical staff working with people living with HIV/AIDS are available on the website: www.phc-ca.org/providers/pubs. The health plan will arrange for follow-up assistance and/or training to providers who report a need for technical assistance.

If PHC California receives a member grievance related to the delivery of culturally or linguistically appropriate care, it will promptly assess the provider's cultural and linguistic competency and implement corrective action if needed.

Contracted providers are expected to provide services in a culturally competent manner that includes, but is not limited to, removing all language barriers to service, and accommodating the special needs of the ethnic, cultural, and social circumstances of the patient. Providers must also meet the requirements of all applicable state and Federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

PHC California operates the health plan pursuant to a Cultural and Linguistic Competency Plan. To obtain a copy of the plan at no charge, you may request one by calling Provider Relations at

(888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. The plan is also available at www.phc-ca.org/providers/pubs.

14.1 PCP Responsibilities for Cultural and Linguistic Services

The California Department of Health Services (DHCS) and PHC California expect providers to adhere to the following:

14.1.1 24-Hour Access to Interpreters

When the provider does not speak the member's language, he/she must ensure twenty-four (24)-hour access to interpreters for members whose primary language is not English.

State and Federal laws state that it is never permissible to turn a member away or limit the services provided to them because of language barriers. It is also never permitted to subject a member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English. Linguistic services must be provided at no cost to the member.

To access interpreters for PHC California members at no cost to you or the patient, call Member Services during normal business hours of 8:30 a.m. to 5:30 p.m. Monday through Friday at:

(800) 263-0067, TTY/TDD 711

14.1.2 After Hours and Nurse Advice Line

After hours, weekends and holidays, you can contact the PHC California Urgent Care/Nursing Advice Line at:

(800) 797-1717/TDD 711

14.1.3 Documentation

If a patient insists on using a family member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document this in the member's medical record. PHC California is available to assist you in notifying members of their right to an interpreter.

All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners should document who provided the interpretation service. That information could be the

name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

14.1.4 Facility Signage

DHCS requires that practitioner offices post important signs in the threshold languages for the area. For assistance with any signage, please contact **PHC California at (800) 263-0067, TTY/TDD 711.**

Section 15: Medication Management

PHC California's pharmacy benefit is carved out to the Department of Health Care Services (DHCS) through Medi-Cal Rx and is managed by DHCS Pharmacy Benefit Manager (PBM), Prime Therapeutics/Magellan Medicaid. Please note, Prime Therapeutics/Magellan is not a contracted vendor of the PHC California Network.

15.1 Medi-Cal Rx Overview

Medi-Cal Rx includes pharmacy services billed as a pharmacy claim, including but not limited to:

- Outpatient drugs (prescription and over the counter), including Physician Administered Drugs (PADs)
- Enteral nutrition products
- Medical supplies

Providers should visit the DHCS website (https://medi-calrx.dhcs.ca.gov/home/) regularly for additional resources, implementation dates and training opportunities.

For assistance by phone, call the Medi-Cal Rx Customer Service Center at (800) 977-2273.

15.2 Prior Authorization Overview

Pharmacy claims submitted to Medi-Cal Rx for drugs and medical supplies are subject to claim UM edits which may require authorization by Medi-Cal Rx before reimbursement can be provided.

Note: The Medi-Cal Rx Contract Drugs List (CDL) is a key resource for determining which drugs are covered and which may require prior authorization. Authorization requirements are based on federal and state law.

Authorization requests are made by submitting a PA request to Medi-Cal Rx. PA requests will be accepted via the following methods:

- NCPDP P4 – Request Only
- Medi-Cal Rx Provider Portal
- CoverMyMeds
- Fax
- U.S. Mail

15.3 Drug Use Review

Federal rules require that each state Medicaid program include a comprehensive Drug Use Review (DUR) program to improve the quality and cost effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.

California's Medicaid DUR program is focused on outpatient medication therapies with the broad goals of improving patient outcomes, increasing the quality of prescribing practices, reducing healthcare costs, and improving member, prescriber, and pharmacist satisfaction. To work towards these goals, the DUR program implements strategies that identify and reduce adverse events, fraud, misuse, overutilization, underutilization, and inappropriate/ineffective care associated with specific drugs or groups of drugs. Strategies for improving prescribing may include education, data reports, audits, alerts, incentives, decision-making tools, and outreach aimed at members, prescribers, and pharmacists.

There are three key functions of the DUR program:

- Prospective DUR
- Retrospective DUR
- Educational Outreach

Central to the DUR program is the Global Medi-Cal DUR Board, which is an advisory body that includes volunteer pharmacists and physicians with active practices in California. The Board advises and makes recommendations to the State on common drug therapy problems, develops criteria to evaluate and improve the quality of drug therapy, reviews evaluations and utilization reports, and recommends educational interventions, as needed, in order to improve prescribing and dispensing practices.

The DUR program promotes patient safety through state-administered utilization management tools and systems that interface with the claims processing systems. Additionally, consistent with 42 CFR §438.3(s)(4) and (5), the Centers for Medicare and Medicaid Services (CMS) requires any Managed Care Organization (MCO) that includes covered outpatient drugs to operate a DUR program compliant with section 1927(g)(3)(D) and 42 CFR 456, subpart K.

Section 16: Medical Record Documentation

16.1 Requirements of Medical Records Documentation

By contract, the Health Plan requires contracted Provider Sites to do the following:

- Maintain an electronic, typewritten or legibly written in ink paper permanent and/or paper medical record system from which clinical information can be retrieved promptly by authorized personnel/health care providers.
- Maintain one medical record for each member.
- Implement measures to protect the medical records from loss, tampering, alteration, and destruction electronically and/or physically.
- Comply with all Federal and State regulations, relevant accreditation standards, AHF policies related to patient confidentiality and release of member's record.
- Use a consistent organized format of its medical records.
- Update and sign member medical records in a timely manner. Discharged patient records are to be completed and filed within **thirty (30) days after termination.**
- All medical records shall be legible and readily available to authorized personnel as stipulated by law.
- Designate a staff member delegated the responsibility of securing and maintaining medical records to ensure that the medical records are handled in accordance with all applicable Federal and State regulations and the Health Plan policies and procedures.
- Keep medical record for a minimum of **ten (10) years** regardless of contract status including exposed X-ray film.
- Make medical records available to the Health Plan or new providers if needed, such as for quality improvement activity and reporting, and utilization management etc.
- Store medical records so as to protect against loss, destruction or unauthorized use.
- File medical records 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 the Department is required for storage of inactive medical records away from the facility.
- Medical records shall be the property of the facility and shall be maintained for the benefit of the patient, health care team and clinic and shall not be removed from the clinic except for storage purposes after termination of services.
- If a clinic ceases operation, arrangements shall be made for the safe preservation of the patients' health records. The Department shall be informed by the clinic of the arrangements within **forty-eight (48) hours** before cessation of operation.

- The Department shall be informed within **forty-eight (48) hours**, in writing, by the licensee whenever patient health records are defaced or destroyed before termination of the required retention period.
- It the ownership of a clinic changes, both the licensee and the applicant for the new license shall, prior to change of ownership, provide the Department with written documentation stating:
- The new licensee shall have custody of the patients' health 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 location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons.

The following information **is required** in each member's medical record:

- A unique medical record number. Member identification on each page; personal/biographical data in the record.
- Demographic information: name, identification number, date of birth, gender, primary language, communication needs (vision, hearing etc.), emergency contact and preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services
- Primary care provider (if applicable)
- Allergies or absence of allergies and untoward reaction to drugs and materials in a prominent location
- Histories and physicals that are updated annually or as needed
- A problem list, a complete record of immunizations and health maintenance or preventive services rendered
- Advance directive information and/or executed
- Age appropriate "Individual Health Education Behavioral Assessment must be documented by having the patient or legal guardian complete the age-appropriate Staying Healthy Assessment Tool and the clinician documenting review and counseling on the form." Referrals to health education services, as applicable, should be documented.
- Consent forms, where applicable, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6
- Significant medical advice given to a member by phone, including after-hours telephone information

- Members involved in any research activity is identified
- Reports of emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions with inpatient and outpatient medication lists reconciled
- Consultations, referrals, Specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
- Records shall be kept current in detail consistent with good medical and professional practice and shall describe subjective complaints, objective findings, the plan for diagnosis and treatment and the services provided to each patient
- All entries shall be dated and be authenticated with name, professional title and classification of the person making the entry

Progress notes are required to be updated in each patient encounter and include the following where applicable:

- Date of the encounter and department
- Member's chief complaint or purpose of visit
- Medication reconciliation including over-the-counter products and dietary supplements
- Physical, mental exams and clinical findings
- Studies ordered, such as laboratory or diagnostic imaging and the results. The provider will have a specific process in place to advise a patient of any abnormal health finding or test result, with evidence of process compliance available in the medical record. Notation of the method of communication, date & time of the notification should be noted. If a follow-up appointment or referral is required evidence of the ordering and/or scheduling should also be noted.
- Referrals/consultation ordered and the results. Any information regarding results of the specialist visit will be recorded by the Provider including reports and the specialists' consultation record with readings, findings, and treatment recommendations. Notation should be made if a follow-up appointment is required.
- Objective Findings/Diagnosis
- Plan for Findings/Diagnosis
- Treatment Plan including all medications prescribed or ordered need to be noted in the chart. Likewise, prescription refills must be documented and dated. Documentation on medications should include drug name, strength, quantity, and instruction for use. Medication education needs to be documented whenever a new medication is prescribed to insure that the patient understands what the medication is for, how to safely take it and

the frequency of dosing.

- All injections, immunizations and medications of any type administered in the facility must be documented, indicating drug name, dosage, route, site, date, time, drug manufacturer, lot number, and signature of administering staff
- Care rendered and therapies administered including preventive care provided or refusal of care or therapies
- Documentation of follow-up instructions and a definite time for return visit or other follow-up care. Time period for return visits or other follow-up care is definitely stated in number of days, weeks, months or PRN (as needed).
- Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit but all problems must be addressed within the calendar year. Documentation must demonstrate that provider follows up with member about treatment regimens, recommendations and counseling.
- Care plan or discharge plan including prescriptions, recommendations, education, instructions, necessity of surgery or other procedures etc.
- Provider signature

Provider sites are required to contact the PHC California member and document the communication in the medical record in the following situations:

- **Missed Appointments**
- **Abnormal laboratory or imaging results**, including a notation confirming that the member was notified of the result
- **Referral results requiring follow-up or clinical attention**, with documentation that the member was informed
- **Discharge from an institution**, such as a hospital, emergency room, or skilled nursing facility
- **Inquiries received outside of regular business hours**

PHC California will audit medical records kept by contracted providers during the Full Scope Facility Site Review at a minimum. Additional monitoring may occur during HEDIS record review and other audits conducted by the Health Plan or required by individual State or Federal requirements.

16.2 Practitioner Responsibilities for Documenting Life-Sustaining Procedures

In accordance with Title 22 of the California Code of Regulations, adult medical records must include documentation of whether the patient has been informed of and has executed an advance directive such as a Durable Power of Attorney for Health Care (DPAHC).

Complete documentation is essential whenever life-sustaining procedures are withheld or withdrawn and should include:

- Patient diagnosis and prognosis, including test results or other evidence that the attending Practitioner and the second confirming Practitioner used in forming their conclusion.
- Declaration of whether the patient is likely to regain mental function and the factors upon which the determination of the patient's mental incapacity was based, when applicable.
- A statement that the patient or surrogate has been fully informed of the facts and the consequences of withholding or withdrawing life-sustaining procedures and that the surrogate decision-maker has consented to the withholding or withdrawing of such procedures.
- A copy of any DPAHC Declaration or non-statutory Living Will signed by the patient.
- A description of any desires orally expressed by the patient and of any discussion with family members or other surrogate.
- A copy of a certified letter of guardianship or conservatorship, when applicable. Clear written orders to withhold or withdraw specific medical procedures.

16.3 PHC California Access to Member Medical Records

Please be advised that **PHC California** requires access to Plan members' medical records for various purposes, including but not limited to, quality assurance, care coordination, compliance monitoring, and regulatory reporting.

The following section is excerpted from your **Provider Agreement** as a reminder of your contractual obligation to support this requirement. In the spirit of mutual cooperation and in the best interest of our shared patients, PHC California expects full compliance with this provision by you and your staff.

> ***Provider Agreement Excerpt:***
>
> 8.3 AHF Access to Medical and Administrative Records and Facilities: Provider will maintain and ensure ready availability of medical records to AHF of all pertinent information relating to the health care of each Enrollee records and papers, risk adjustment validation data, computer or other electronic systems relating to the

Covered Services provided to the Enrollees, the quality, appropriateness, timeliness, and cost of those services, and any payments received by Provider from Enrollees (or from others on their behalf), and unless the Provider is compensated on a fee-for-service basis, to the financial condition of the provider. (Cal. Health & Safety Code, § 1300.67.8(c).)

Specifically, and without limiting the foregoing, AHF shall have the right to access/inspect Provider facilities and records for purposes of paying Provider, as well, as to perform quality management utilization monitoring and peer review activities. Provider shall require any and all Subcontractors to be bound by this paragraph.

Should you have any questions or concerns regarding medical record access by the Plan, you are encouraged to contact **Provider Relations** for assistance.

16.4 Chart Review Requirements

Upon receipt of medical records for case review, clinical record audits, or other considerations, details of the clinical documentation will be considered. If a record is found to be lacking in any of the required elements or procedural follow-ups required, where indicated, the provider will be contacted to discuss findings. In the event clinical documentation discrepancies are sufficient to warrant more than a verbal discussion, Provider Relations will be required to work with the provider, in conjunction with clinical management (i.e. Directors of UM, QM or Medical Director), to remediate the discrepancies. All providers who require this level of intervention are expected to comply with the training and/or education so the medical records can accurately and appropriately reflect the standards of care expected for Plan members.

16.5 Immunization Reporting Requirements

PHC California requires compliance with state laws mandating that all California healthcare providers who administer vaccines to report patient-specific immunization information to the **California Immunization Registry (CAIR)** within **fourteen (14) calendar days**.

Section 17: Infection Control Practices

The Medical Administration Policy and Procedure Committee adopted by PHC California Managed Care Utilization Management Committee (UMC) has approved the use of clinical practice guidelines for HIV/AIDS published by the U.S. Department of Health and Human Services (DHHS). This information is available at: https://clinicalinfo.hiv.gov/guidelines
Please refer to these guidelines for treatment de-escalation in HIV infected adults and adolescents and virological control.

17.1 Disease Reporting Statement

PHC California complies with disease reporting standards as cited by Section 2500 of Title 17 of the California Code of Regulations, which requires public health professionals, medical Providers, and others to report approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Forms to report the required diseases or conditions as well as additional information are available at:
https://admin.publichealth.lacounty.gov/phcommon/complaints/phcomp.cfm

17.2 Staff Safety Training Requirements – Facility Site Review (FSR) Compliance

In accordance with the **California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Facility Site Review (FSR) Full Scope Survey** requirements, site personnel must receive documented training and/or information in the following areas:

1. **Infection Control and Universal Precautions** – Training must be completed **annually**
    - *Reference: 8 CCR §5193; 29 CFR §1910.1030*
2. **Bloodborne Pathogen Exposure Prevention** – Training must be completed **annually**
    - *Reference: 8 CCR §5193; 29 CFR §1910.1030*
3. **Biohazardous Waste Handling** – Training must be completed **annually**
    - *Reference: CA Health & Safety Code §117600*
4. **Recognition and Reporting of Child, Elder, and Domestic Violence Abuse**
    - *Reference: CA Penal Code §§11164, 11168*

All training must be documented and readily available for review during facility site inspections.

17.3 Infection Control

Similarly, DHCS/MMCD FSR requires providers to adhere to the following criteria:

A. Infection control procedures for Standard/Universal precautions are followed. (8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042)
    1) Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.
    2) A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms.
    3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.

B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. (8 CCR §5193 (Cal OSHA Health Care Worker Needle stick Prevention Act, 1999); H& S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.)
    1) Personal Protective Equipment is readily available for staff use.
    2) Needle stick safety precautions are practiced on site.
    3) All sharp injury incidents are documented.
    4) Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.
    5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.
    6) Contaminated laundry is laundered at the workplace or by a commercial laundry service.
    7) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.
    8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.

C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. (8 CCR §5193; CA H&S Code §118275)
    1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.

2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.

3) Disinfectant solutions used on site are:

    - approved by the Environmental Protection Agency (EPA).
    - effective in killing HIV/HBV/TB.
    - used according to product label for desired effect.

D. Reusable medical instruments are properly sterilized after each use. (22 CCR §53230, §53856)

1) Written site-specific policy/procedures or Manufacturer's Instructions for instrument/equipment sterilization are available to staff.

2) Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:

    - Cleaning reusable instruments/equipment prior to sterilization
    - Cold chemical sterilization
    - Autoclave/steam sterilization
    - Autoclave maintenance

3) Spore testing of autoclave/steam sterilizer with documented results (at least monthly)

4) Sterilized packages are labeled with sterilization date and load identification information.

Please note these are ***minimum standards***. As new information becomes available and/or new policies and procedures are developed, the Provider Relations Department will communicate updates to you via fax, Provider Newsletters, and/or presentations delivered by the Physician Chair or a designee of the **Infection Prevention and Control Committee (IPCC)** during Provider Meetings.

Section 18: Environmental Safety

18.1 Safety Program

Any facilities providing healthcare services need to adhere to all Federal, State, local and regulatory agency laws, rules and regulations regarding fire and safety. The Occupational Safety & Health Administration (OSHA) states that people have the right to a safe work environment, and employers must take the proper precautions to maintain safety in the workplace. Equally important is the right that patients have to receive their care & treatment in a safe environment.

18.2 Training

Per the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division's (MMCD) Facility Site Review (FSR) Full Scope Survey, site personnel receive documented safety training/information in: (8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030)

A. Site personnel are qualified and trained for assigned responsibilities. CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035)

1) Only qualified/trained personnel retrieve, prepare or administer medications.
2) Only qualified/trained personnel operate medical equipment.
3) Documentation of education/training for non-licensed medical personnel is maintained on site.
4) There is evidence that staff has received safety training and/or has safety information available in the following:
    - Fire safety and prevention
    - Emergency non-medical procedures (e.g. site evacuation, workplace violence)

B. Site environment is maintained in a safe, clean and sanitary condition for all patients, visitors and personnel. (8 CCR §5193; §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34)

1) All patient areas including floor/carpet, walls, and furniture are neat, clean and well maintained.
2) Restrooms are clean and contain appropriate sanitary supplies.
3) The following fire and safety precautions are evidenced on site:

- Lighting is adequate in all areas to ensure safety.
- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Exit doors are clearly marked with "Exit" signs.
- Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.
- Electrical cords and outlets are in good working condition.
- At least one type of firefighting/protection equipment is accessible at all times.
    - Fire extinguishers shall be maintained in a fully charged and operable condition and kept in their designated places at all times except during use.
    - Smoke detectors with intact batteries
    - Automatic sprinkler system with a 10-inch clearance between sprinkler heads and stored materials

C. Employee Alarm System

Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them. (29 CFR 1910. 37) OSHA:

For those employer's with ten (10) or fewer employees in a particular workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system.

D. Emergency health care services are available and accessible twenty- four (24) hours a day, seven (7) days a week. (22 CCR §51056, §53216; 28 CCR §1300.67**)**

1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.
2) Emergency equipment is stored together in easily accessible location.
3) Emergency phone number contacts are posted.
4) Emergency medical equipment appropriate to practice/patient population is available on site:

- Airway management: oxygen delivery system, oral airways, nasal cannula mask, and Ambu bag.
- Emergency equipment and medication are available and in an accessible location, ready for use. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive device.
- Minimum equipment includes Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg/ml (injectable), appropriate sizes of ESIP needles/syringes*and alcohol wipes, Naloxone, chewable aspirin, nitroglycerin spray/tablet, nebulizer or metered dose inhaler, and glucose. Asthma exacerbation, chest pain, hypoglycemia management per American Academy of Family Practice (AAFP) recommendations. Medication dosage chart (or other method for determining dosage) is kept with emergency medications, in the emergency kit.

5) There is a process in place on site to:
   - Document checking of emergency equipment/supplies for expiration and operating status at least monthly.
   - Replace/re-stock emergency equipment immediately after use.

E. Medical and lab equipment used for patient care is properly maintained. (CA Health & Safety Code §111255; 28 CCR §1300.80; 21 CFR §800-1299)

1) Medical equipment is clean
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines

There is documented evidence that standard operating procedures have been followed for routine inspection/ maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

Please note these are ***minimum standards***. As new information becomes available and/or new policies and procedures are developed, the Provider Relations Department will communicate updates to you via fax, Provider Newsletters, and/or presentations delivered by **the Director of Safety and Security** or designee at Provider Meetings.

Section 19: Oversight Monitoring

19.1 Compliance and Oversight Monitoring

The Medi-Cal contract between the **California Department of Health Care Services (DHCS)** and **PHC California** outlines a number of performance requirements that must be met by both **PHC California** and all **contracted providers**, including those participating through descending contracting relationships (subcontracts), who agree to deliver services to eligible and enrolled PHC California members.

These requirements include, but are not limited to:

- The Provider's agreement to maintain books and records for a period of **five (5) years** and make such documents available to regulatory agencies.
- Medical records must be maintained for **ten (10) years**.
- The Provider's agreement to furnish PHC California with encounter data.
- The Provider's agreement to participate in medical and other audits (e.g. Healthcare Effectiveness Data and Information Set (HEDIS) and/or mandated) conducted by DHCS and other regulatory agencies. This means sending medical records free of charge when requested.

Providers are encouraged to review their contracts with PHC California to ensure thorough understanding of all applicable performance requirements, including those outlined in the Medi-Cal contract and any additional obligations specified therein.

19.2 Provider Relations Oversight Monitoring

The Medi-Cal contract between **DHCS** and **PHC California** outlines a number of performance requirements that must be met by both **PHC California** and all **contracted providers.** To ensure ongoing compliance, PHC California conducts continuous monitoring and evaluation of provider performance.

- Compliance with applicable federal and state laws and regulations
- Provider-to-Patient Ratios.
- Geographic Access Standards
- Appointment Availability Survey Results.
- Member Access and Availability Grievance Trend Analysis

19.3 Monitoring Access to Care

PHC California's **Provider Relations Department** utilizes various methods to study and monitor access to care at the provider level. The **access standards** referenced above serve as benchmarks for assessing compliance.

Monitoring methods may include, but are not limited to:

- **Telephone, mail, or email surveys** to assess member experiences and provider responsiveness.
- **Review of appointment availability** to ensure compliance with access standards for routine, urgent, and specialty care.
- **Analysis of reports**, such as the **Geo-Access Report**, to evaluate network adequacy and provider distribution.
- **Review of member waiting times** in provider offices to assess timeliness of care delivery.

Access to and availability of care is regularly reported and monitored during **Member Provider Committee (MPC)** meetings. Any identified issues that cannot be resolved within the MPC are referred to the appropriate department or committee for further action. These may include, but are not limited to, the **Credentialing Committee**, **Provider Relations**, **Quality Improvement (QI)**—particularly the **Facility Site Review (FSR) Program**—or the **Compliance Department**.

Section 20: Compliance Program

PHC California is committed to protecting and preserving the integrity and availability of health care resources through the operation of a comprehensive Compliance Program. The Plan recognizes the critical importance of preventing, detecting, and investigating Fraud, Waste, and Abuse (FWA) to ensure accountability and safeguard public funds.

To support these efforts, PHC California has established a Special Investigations Unit (SIU) responsible for overseeing and enforcing adherence to the Plan's Compliance and Anti-Fraud Plan. The SIU conducts investigations, coordinates with regulatory and law enforcement agencies as appropriate, and ensures that all FWA-related activities align with applicable federal and state regulations.

20.1 Fraud Waste and Abuse (FWA)

Fraud, Waste, and Abuse (FWA) undermine the integrity of the health care system and divert valuable resources away from patient care. Fraud involves intentional deception for unauthorized benefit, waste refers to the overuse of services or resources, and abuse includes practices that result in unnecessary costs to health care programs. PHC California is committed to detecting, preventing, and reporting FWA through a robust Compliance Program, ongoing monitoring, and collaboration with providers, members, and regulatory agencies. Reporting suspected FWA is essential to maintaining ethical, efficient, and lawful health care delivery.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge,

and available evidence, among other factors.

20.2 Special Investigations Unit (SIU)

The Special Investigations Unit (SIU) conducts investigations involving providers, suppliers, members, or other healthcare entities to assess whether billed services are appropriately supported by documentation. These investigations may include, but are not limited to, requests for medical records, documentation reviews, and on-site visits to validate the accuracy and appropriateness of services rendered and billed.

In instances where PHC California identifies a potential overpayment, the Health Plan will issue a written notice to the provider outlining the findings and specifying the amount identified as overpaid, along with any applicable repayment instructions or appeal rights as defined under contractual and regulatory provisions.

20.3 Reporting and Investigations

Federal and state regulations require PHC California to collaborate with its provider network to identify and report potential cases of health care fraud, waste, or abuse to appropriate law enforcement and regulatory agencies.
Common examples of fraudulent acts include, but are not limited to:

- A member receiving a bill for services that are covered by PHC California.
- A member receiving a bill for services that were never performed.
- A provider submitting claims for duplicate, unbundled, or upcoded services.
- A supplier or equipment vendor billing for items not ordered by a physician or not delivered to the member.

An individual using another person's PHC California identification card to obtain services.
All suspected incidents of fraud, waste, or abuse should be reported to PHC California immediately. Reports may be submitted to the PHC California Compliance Department through the following channels:

- **Compliance Hotline** (Anonymous): 1 (800) AIDS-HIV. The Compliance Hotline is available twenty-four (24) hours a day, seven (7) days a week.
- **Email:** PHC-Compliance@ahf.org
- **In writing:**

PHC California
Attn: Compliance Officer
1710 N. La Brea Ave.
Los Angeles, CA 90046

PHC California maintains a strict **non-retaliation policy** to protect individuals who report suspected misconduct in good faith.

Providers, First Tier, Downstream, and Related Entities (FDRs), and any other delegated entities with contractual obligations are required to report suspected fraud, waste, or abuse in accordance with the terms and conditions of their contract and applicable PHC California policies and procedures.

PHC California will, when appropriate, report suspected FWA cases to local, state, and federal agencies, including law enforcement, regulatory bodies, and applicable oversight entities.

20.4 Non-Retaliation

PHC California maintains a strict non-retaliation policy. Neither PHC California nor any of its contracted entities shall retaliate against any employee, temporary employee, contractor, or agent who, in good faith, reports suspected Fraud, Waste, or Abuse (FWA), or violations of the Code of Conduct to PHC California or to any regulatory or enforcement agency.

Retaliation, intimidation, or any form of adverse action against individuals for making a good faith report is strictly prohibited and may result in disciplinary action, up to and including termination of employment or contract.

20.5 Annual Fraud Waste and Abuse and General Compliance Training

All PHC California providers are required to ensure that their employees and contracted downstream entities complete Fraud, Waste, and Abuse (FWA) training within ninety (90) days of hire or contract execution, and annually thereafter.

This requirement aligns with federal and state compliance obligations, including those set forth by the Centers for Medicare & Medicaid Services (CMS), and is intended to promote ethical practices, regulatory adherence, and the prevention of improper billing or conduct within the provider network.

Section 21: Quality Improvement Program

PHC California Quality Improvement Program (QIP) is written to assure that the quality of health care provided to members meets or exceeds established community, professional, regulatory and accreditation standards. The QIP supports a data-driven framework through which the delivery of care is continuously monitored, evaluated, and improved.

While many components of the QIP are addressed in other sections and administered by various departments, these activities remain integral to the overall program.

Oversight of the QIP is provided by PHC California's Executive Oversight Committee (EOC) of the Board of Directors, which is responsible for ensuring effective implementation, accountability, and alignment with organizational quality goals.

PHC California's QIP is designed to ensure that quality of care and quality of service issues are tracked and trended to review, identify, and analyze opportunities for improvement and that appropriate corrective actions are taken to address problems. The vehicle used to monitor quality activities is the Quality Improvement and Health Equity Committee (QIHEC). All Providers are invited via fax and requested to RSVP to Provider Relations Department. Quality Improvement activities will not be delegated directly to contracted providers. However, providers cooperate with QI activities and allow the organization to use their performance data.

In brief, the QIP features review of outcomes data (such as HEDIS) complaints/grievances (see Section 11 on Grievances), potential quality investigations, access and availability, member experience of care surveys (CAHPS), member health outcomes survey (HOS-Medicare only), provider satisfaction surveys, accreditations, population health and disease management programs, medical record reviews, facility site reviews, education of providers on practice guidelines, health education aligned with approved practice guidelines for members (see Section 12 on Health Education), the model of care: chronic disease management, pharmacy and adherence to medication, and performance improvement projects. This comprehensive program is completed through the efforts of committees that report to the QIHEC.

21.1 Highlights of Selected Quality Activities

Adherence to Medication

PHC California's primary key performance indicator is Viral Load Suppression, which serves as a critical measure of clinical outcomes for members living with HIV. Achieving and maintaining viral load suppression requires consistent adherence to prescribed antiretroviral therapy.

This indicator is actively monitored and reviewed during each QIHEC meeting to assess trends, identify barriers, and guide targeted interventions.

HEDIS (Healthcare Effectiveness Data and Information Set)

Participating providers are required to support and participate in HEDIS (Healthcare Effectiveness Data and Information Set) measures as part of compliance with Centers for Medicare & Medicaid Services (CMS) regulations for reimbursement under government programs such as Medi-Cal and Medicare.

As stipulated in their contractual agreements, providers agree to submit medical records and related documentation upon request to the Health Plan for purposes of HEDIS data collection or any other review conducted by regulatory or accrediting entities, including but not limited to CMS, the Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA).

PQI (Potential Quality Investigation)

A Potential Quality Issue (PQI) is a process used to initiate an investigation into a quality of care or quality of service concern that appears to demonstrate a trend or recurring pattern.

To initiate a PQI, the submitter must complete the PQI Submission Form, clearly outlining the concern, and submit it to the Quality Department for review and follow-up.

Please Note: This process is not intended to serve as a mechanism for filing a complaint or grievance. Information regarding complaints and grievances can be found in the section titled "Complaints and Grievances."

The results of each investigation are reviewed by the RN Risk Manager and the Plan Medical Director. In addition, tracking and trending of investigation outcomes are reported to the QIHEC for oversight and monitoring.

CAHPS (Consumer Assessment of Healthcare Providers & Systems)

PHC California participates in CAHPS annually. These surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. The surveys focus on matters that patients themselves say are important to them and for which

patients are the best and/or only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers

CAHPS is a patient experience survey. Patient experience surveys sometimes are mistaken for customer satisfaction surveys. Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not how satisfied they were with their care. Patient experience surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, experience with front office staff and the coordination of their healthcare needs. They do not focus on amenities.

CAHPS surveys follow scientific principles in survey design and development. The surveys are designed to reliably assess the experiences of a large sample of patients. They use standardized questions and data collection protocols to ensure that information can be compared across healthcare settings. Finally, many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.

CAHPS surveys are an integral part of CMS' efforts to improve healthcare in the U.S. Some CAHPS surveys are used in Value-Based Purchasing (Pay for Performance) initiatives. These initiatives represent a change in the way CMS pays for services. Instead of only paying for the number of services provided, CMS also pays for providing high quality services. The quality of services is measured clinically, administratively, and through the use of patient experience of care surveys. For more information please view the CAHPS website at:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/

21.2 Model of Care

As an added benefit to our members, AHF Plans utilize a Centers for Medicare & Medicaid Services (CMS)-approved Model of Care (MOC) as the foundational framework for managing chronic conditions. The MOC outlines the Plan's commitment to delivering services through a structured Chronic Disease Management Program, designed to support improved health outcomes, care coordination, and member engagement.

This program is built upon a collaborative relationship among the Plan's RN Care Team Manager (RNCTM), the Primary Care Provider (PCP), and the member. Additional participants—such as family members, significant others, or other healthcare professionals including social workers—may be involved in the care team as needed or upon request, to support a comprehensive and person-centered approach to care.

The high-level steps of the program include:

- Identifying chronic disease status by using the Health Risk Assessment (HRA) by RN Care Manager (RNCM). Every member in our Plans has at least one chronic condition HIV/AIDS. Primary Care Providers are required to sign off receipt of the HRA which will be sent on behalf of the members Care Manager.
- Severity Level (SL) are calculated from HRA results (SL 1, 2 or 3 – 3 being most severe)
- Members assigned SL 3 are place under complex care management – the rest are placed in the chronic disease management program or a population health program.
- A Care Plan is established with at least the member and Primary Care Provider including establishing goals with the final version shared with the member's care team. Primary Care Providers are required to sign off receipt of the Care Plan which will be sent on behalf of the members Care Manager.
- Interdisciplinary Care Team Meetings are held to coordinate care & discuss best options for care and its delivery
- Ongoing support continues by RNCTM – working the care plan – teaching self-management to member
- Annual re-evaluation of member is completed by RNCTM and shared with care team.

The **Quality Improvement (QI)** Department produces an **annual Model of Care (MOC) Dashboard** to evaluate the effectiveness of MOC implementation for all members. The results are presented to the QIHEC and EOC of the Board of Directors. Summary findings are shared with both providers and members, typically through **newsletters** or, when appropriate, via **blast fax** to providers.

21.3 Accreditations

PHC California has full three (3) year accreditation from Accreditation Association for Ambulatory Health Care (AAAHC). AAAHC accreditation means that the organization participates in on-going self-evaluation, peer review and education to continuously improve its care and services. The organization also commits to a thorough, on-site survey by AAAHC surveyors, who are themselves health care professionals, at least every three years.

21.3.1 Facility Site Review and Medical Record Review

- PHC California's responsibility to its members is to contract with providers of health care who provide safe, comfortable offices and deliver high quality medical care.
- The Provider/Clinic to be reviewed will be advised in advance, by telephone and in writing, of the selected date(s) for the audit of his/her office/facility. Using the approved DHCS Facility Site Reviews Checklist, PHC California's assigned/credentialed Facility Site Review

Nurse will visit the Provider's site on the previously arranged date (see DHCS Facility Review Checklist).

- Results of each audit will be reviewed by the Facility Site Review Nurse for compliance with and maintenance of standards. Results of the completed site audit will be conveyed to the Provider, where applicable. Quality Improvement Corrective Actions will be implemented as necessary following the review. Facility Site Review scores are shared with the Credentialing and Peer Review Office and filed in the appropriate providers file for re-privileging and re-contracting purposes. For more details on Facility Site Review and review forms, please refer to the chapter on Physician Facility Licensure, section 21

21.3.2 Medical Record Review

- PHC California has a responsibility to ensure that ambulatory medical records are maintained to document that care has been provided appropriately. This includes pediatric, if applicable, and adult health care.
- The provider to be reviewed will be advised in advance, either by telephone or in writing, of the selected dates for the audit of their ambulatory medical records. Using the Medical Record Audit Tool, the Facility Site Review Nurse will review the selected charts for appropriate medical records management and documentation. Whenever possible, the facility audit and medical record review will be conducted concurrently. Quality Improvement corrective actions will be implemented as necessary following the review. For more details, refer to Chapter 15 Medical Record Documentation.

21.3.3 Corrective Action Plans

When it is found that Providers do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this Manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans (CAP) will be forwarded to providers and will include corrective actions and dates by which corrective actions are to be achieved.

PHC California representatives will work with and offer support to providers to ensure the timely resolution of CAP requirements. Providers who fail to respond to an initial corrective action plan by the date specified will be provided with a second iteration of CAP requirements and may be assigned an extended action plan due date. Ongoing monitoring of compliance with any corrective action will be a joint effort, with Quality Management leading the effort, in cooperation with Provider Relations.

21.3.4 Non-Compliance with Quality Improvement Corrective Actions

The **PHC California Quality Management Department** may assist providers in the development and implementation of a **Corrective Action Plan (CAP)** when quality deficiencies are identified. Providers are expected to fully comply with all required corrective actions.

Failure to comply with Quality Improvement corrective actions may result in one or more of the following actions:

- Direct contact from PHC California's Quality Management Department
- Referral to the **Credentialing and Peer Review Committee** and/or the **Compliance Committee**, as appropriate
- In-service training or targeted educational interventions
- Implementation of a **Provider Compliance Department corrective action program**, which may include the following sanctions:
    - Suspension of new member enrollments
    - Reassignment of existing members to an alternative provider
    - Formal termination of the provider's contract with PHC California

21.3.5 Corrective Action Verification Review

Corrective action verification reviews are conducted to verify that corrective actions have been effectively implemented and have resulted in improved compliance with previously identified deficiencies.

21.3.6 Child Health and Disability Prevention (CHDP) Reviews

The **Child Health and Disability Prevention (CHDP) Program**, part of the **Children's Medical Services State Program**, is a preventive health initiative serving California children and youth under the age of 21. Although **PHC California currently does not enroll members under 21 years of age**, the Plan supports the CHDP program's objectives by promoting regular preventive health assessments aimed at identifying and treating health issues early, thereby preventing or reducing the severity of illness.

Through this program, PHC California ensures access to **preventive health care** for eligible members and supports **continuity of care** through the member's designated **Primary Care Practitioner (PCP)**.

Medical Record Review and CHDP Integration

- The **Medical Record Review Tool** used by PHC California incorporates **CHDP-specific questions** to evaluate compliance with preventive care standards.
- Providers scheduled for review will be notified in advance—either by **telephone or in writing**—of the review date.
- A **licensed PHC California staff member** will review a specified number of medical records. CHDP review activities may occur concurrently with the routine medical record review.

Corrective Action and Follow-Up

- Providers who do not meet CHDP standards will receive **written notification** outlining the deficiencies.
- **Quality Improvement corrective actions** will be implemented as necessary based on the audit findings.

For more information, refer to **Section 11 – Children's Services** of this manual.

21.4 Perinatal/Postpartum Services Program

If clinically indicated, PHC California will refer any pregnant member to an OB/GYN with expertise in managing high-risk pregnancies involving HIV.

21.5 Skilled Nursing Facility (SNF) Workforce Quality Incentive Program (WQIP)

SNF WQIP is a Medi-Cal program that provides performance-based directed payments to SNF facilities to incentivize workforce and quality improvements. The program is currently in effect for services provided between January 1, 2023, and December 31, 2026. Eligible facilities include freestanding SNF Level-B and adult freestanding subacute facilities Level-B.

PHC California makes incentive payments to its qualifying network providers at a per diem amount determined by Medi-Cal based on the state's quality metrics. To receive WQIP incentive payments from PHC California, facilities must have network provider agreements with the Health Plan.

THANK YOU FOR YOUR PARTICIPATION IN THE PHC CALIFORNIA NETWORK.