TABLE OF CONTENTS

Section 8: Utilization Management 8-1
Utilization Management Program Overview 8-1
Counseling Members on Treatment Options 8-1
Availability of Medical Review Criteria 8-1
Inpatient Care 8-1
Hospital Care 8-2
Utilization Management Staff Availability 8-4
Referrals to In-Network/Out-of-Network Providers 8-5
Continuity of Care 8-5
Obtaining a Second Opinion 8-6
Covered Services that Don't Need Prior Authorization/Referral 8-6
Standing/Extended Referrals 8-7
Affirmative Statement on Incentives 8-7
Submitting Requests for Authorizations 8-8
Advantages of Submitting Authorizations Online vs. Fax 8-8
Turnaround Time for Prior Authorizations 8-9
Emergency/Urgent Care Services 8-9
Inpatient Admissions 8-10
Inpatient Concurrent Review 8-14
Initial Health Appointments 8-14
Adult Preventive Guidelines 8-16
Annual Cognitive Health Assessment 8-17
Pediatric Preventive Guidelines 8-18
Blood Lead Screening of Young Children 8-19
Early Periodic Screening, Diagnostic Treatment (EPSDT) and California Health and Disability Program (CHDP) 8-20
Vaccines for Children (VFC) 8-21
Developmental Disabilities Services (DDS) 8-25
Regional Centers 8-25
California Children's Services (CCS) 8-27
Children with Special Health Care Needs (CSHCN) 8-29
Family Planning Services 8-29
Sensitive and Confidential Services for Adolescents and Adults 8-30
Facility/Ancillary Referrals and Authorizations 8-31

UTILIZATION MANAGEMENT PROGRAM OVERVIEW

Health Plan has Utilization Management (UM) policies and procedures that support the provision of quality and equitable health care services. The goal of UM is to provide Members with the right care, in the right place, within the most appropriate timeframe. The UM program staff can provide guidance to Providers to help support care in all clinical settings and situations including hospital admissions (both medical and psychiatric diagnoses), Long Term Acute Care, emergency situations, ancillary support, and Long-Term Care.

The key objective of Health Plan's UM Program is to improve access to care, maintain the highest quality, and create healthy outcomes, while providing the most cost-effective care possible considering the Member's needs.

COUNSELING MEMBERS ON TREATMENT OPTIONS

Every Provider has the responsibility of counseling Members as to the course and options in medical treatment regardless of whether it is a covered benefit or not. The UM Department will assist and provide care coordination, case and/or disease management services for Members at risk for substantial ongoing care. The UM Department will also assist in establishing whether the Member is eligible for other medical programs available through the State or in the local community.

AVAILABILITY OF MEDICAL REVIEW CRITERIA

The UM department conducts timely prospective, concurrent, and retrospective review of requested care and services. Licensed clinical staff evaluate treatment requests ensuring that services are medically necessary and congruent with evidence-based, nationally recognized clinical guidelines. At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan at (888) 936-7526. Appropriately licensed professionals supervise and monitor all authorization decisions. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist may defer, modify or deny a request for services based on medical necessity.

INPATIENT CARE

Health Plan uses nationally recognized, evidence-based clinical guidelines, including but not limited to MCG, to guide medical necessity review for admission, length of stay and treatment options. It is imperative that the Facility team and Health Plan work together for the clinical benefit of the Member, discharge planning and transitions of care coordination, and for clarity in claims processing.

At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan at (888) 936-7526. Appropriately licensed professionals supervise and monitor all authorization decisions. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist may defer, modify, or

deny a request for services based on medical necessity.

HOSPITAL CARE

Planned (elective) admissions
The admitting physician or hospital must obtain authorization from Health Plan prior to the Member's admission. Prior authorization requests are processed within 5 business days of receipt of the request and supporting clinical documentation reasonably necessary to make a decision, or in the case of an urgent request, within 72 hours of receipt of the request and documentation. If additional information is needed, the decision may be deferred, and the time limit extended an additional 14 calendar days. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. Requests may be submitted online through the Provider Portal Doctor's Referral Express (DRE) at www.hpsj.com/Providers, or by fax at 209-942-6302. See section 8, page 5 of this manual for additional information.

Observation
If a patient is seen in the ER and held for observation (not admitted), observation services are paid per the contracted rate for up to 24 hours. Observation services beyond 24 hours require notification and clinical documentation to support medical necessity, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/Providers, or by fax at 209-762-4702. See section 8, page 6 of this manual for additional information.

Emergency Admissions
If a patient is seen in the ER and admitted for stabilization and further treatment, no authorization is required for services required to stabilize the Member. The hospital must, within one business day after admission, notify and provide clinical documentation to support medical necessity of ongoing inpatient services, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/Providers, or by fax at 209-762-4702.

Post Stabilization
California Health and Safety Code1262.8, includes various provisions regarding emergency and post-stabilization care. Post-stabilization care is defined as medically necessary care provided after an emergency medical condition has been stabilized as defined by subdivision (j) of Section 1317.1.

Health Plans required to provide specific health plan contact information and 24-hour access to request prior authorizations for post-stabilization care when a Health Plan Member receives emergency medical care from a non-contracted hospital.
If treating an Health Plan patient with an emergency medical condition, as defined by 1317.1, a prior authorization is required from Health Plan for post-stabilization care. The stabilizing hospital should conduct the following:

i. The hospital shall contact **Health Plan UM at the following phone number 209-461-2205** to obtain timely authorization for post-stabilization care

Health Plan requests the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary to make a decision in authorizing post-stabilization care or to assume management of the patient's care by prompt transfer. Health Plan shall not require a

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Mountain Valley Health Plan

hospital representative or a physician and/or surgeon to make more than one telephone call to the number provided in advance by Health Plan. The representative of the hospital may be but is not required to be a physician and/or surgeon.
When Health Plan is contacted by a stabilizing hospital and within 30 minutes from the time of the initial contact, Health Plan shall conduct either of the following:

i. Authorize post-stabilization care
ii. In case of a potential transfer, inform the hospital that it will arrange for the prompt transfer for the enrollee to another hospital.

Admitting facility should fax admission face sheet and clinical documentation to the Inpatient Department fax, 209-762-4702. Assigned Concurrent Review Nurse will collaborate with the facility in discharge planning.

A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for post-stabilization care rendered to the enrollee if any of the following occur:

i. The health care service plan authorizes the hospital to provide post-stabilization care.
ii. The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize post-stabilization care or to promptly transfer the enrollee within the timeframe noted above. The request shall be deemed authorized.
iii. There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires post-stabilization care.

An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

Continued Stay (Concurrent) Review
If a Member requires additional inpatient services beyond the approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care. Requests may be submitted online through the Provider Portal (DRE) at www.hpsj.com/Providers, or by fax at 209-762-4702. The requests are processed within 72 hours from receipt of the request and supporting clinical documentation reasonably necessary to make a decision.

* A patient is stabilized, or stabilization has occurred when, in the opinion of the treating Provider, the patient`s medical condition is such that, within reasonable medical probability, no material deterioration of the patient`s condition is likely to result from, or occur during, the release or transfer of the patient. California Health And Safety Code Section 1317.1, Section (j)

Retrospective Protocol
A network Provider or Practitioner may request retrospective authorization for Covered Services rendered to a member when the request is made 1) within thirty (30) calendar days after the initial date of service, *and* 2) if

one of the following conditions apply:

a. The Member has Other Health Coverage (OHC);
b. The Member has a retrospective eligibility segment; or
c. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, and/or HPSJ eligibility at the time of service.
d. The request is for NEMT provided outside of business hours for members transported from the hospital to home. The request must include a completed HPSJ/MVHP PCS form validating the need for this type of service.
e. Requests for Physical Therapy (PT) can be submitted retrospectively if it is identified upon intake that the member had been treated by a different PT in the past rolling 12 months.

Out-of-network/non-contracted providers are not eligible to request retrospective authorizations.
If while doing an Outpatient procedure, the MD notices that another procedure is necessary but has not been authorized, it is ok to submit a retrospective authorization ASAP, but within 30 calendar days of the service being rendered.

Retrospective Eligibility Segment: This occurs when a member who is seen by a provider to receive services but does not have Medi-Cal eligibility or it has changed. DHCS will grant eligibility retrospectively and we would honor that as part of this protocol. For example, a member is seen in your office January 5, 2024, and DHCS retrospectively determines the member to be eligible and provides notification in February that the member is eligible from January 1 and forward.

Decision and Notification Requirements: All requests for retrospective review are required to be determined and a notification to the member and requesting provider within 30 Calendar Days of receipt of all information necessary to make a decision.

Submission Requests: When submitting your retrospective authorization request, please include a completed authorization request form with the Retrospective Review box checked and all clinical information demonstrating medical necessity of the request.

Please direct questions to your Provider Services Representative who will work with Utilization Management to address your questions.

UTILIZATION MANAGEMENT STAFF AVAILABILITY

Providers are encouraged to contact Health Plan's Utilization Management Staff and the Medical

Directors to discuss referrals, case management services for specific Members, or other areas of concern.

UM Staff Availability during Normal Business Hours

Health Plan's UM staff Members are available Monday through Friday from 8:00 am to 5:00 pm pacific time to receive and respond to inquiries regarding UM issues from Members and Providers. UM staff Members can be reached at (209) 942-6320 or (888) 936-7526. Providers can also contact

the Intake Processor of the Day (IPOD) located on the Provider Portal who can assist with Authorizations or questions. The phone number to reach the Medical Director regarding an UM issue is (209) 942-6353.

UM Staff Availability After Hours

Hospitals who need urgent authorization for admission may call 209-461-2205, 24 hours/day, 7 days/week. Providers who need assistance with routine matters may leave a secure voice mail message after normal business hours at (209) 942-6320. Voice mail messages are retrieved each business day at 8:00 am by a Customer Services Representative who responds to the call or routes the message to the appropriate UM staff Member. Responses to voice mails are returned no later than the next business day.

REFERRALS TO IN-NETWORK/OUT OF NETWORK PROVIDERS

Health Plan maintains a wide network of Providers to ensure that most health care needs can be provided within the Service Area. These Network Providers are best prepared to accept referrals and operate within the guidelines established by Health Plan. These Providers also meet the standards for timely and geographic access for our Members. If Providers are experiencing difficulty in locating a local Provider that can meet the Member's medical needs, they should contact the UM Department at (209) 942-6320.

In some cases, Health Plan may have exclusive contracts with specialty Providers. In these instances, referrals must be directed to these Providers. Currently all laboratory, all behavioral health, and some vision and durable medical equipment services are contracted through specific vendors. For more information on referral to Providers please contact the UM Department at (209) 942-6320.

If Covered Services are needed from an out-of-network Provider, the UM Department should be contacted at (209) 942-6320 in order to obtain approval for the referral. Health Plan's Contracting Department will contact Providers that may be available to meet the clinical needs of the Member.

CONTINUITY OF CARE

Health Plan provides continuity of care for Members when their Provider is no longer part of the network or when the Member is transitioning from Medi-Cal fee-for-service (FFS) to Health Plan or from another managed care plan to Health Plan, upon request. Health Plan Members can continue to see their non- contracted Provider for up to 12 months when:

- Member has an existing relationship with the Provider
- Provider accepts Health Plan's reimbursement rate or Medi-Cal FFS rate
- Provider is in good standing and does not have any disqualifying quality of care issues
- Provider is a California State Plan Provider

- Provider supplies Health Plan all relevant treatment information

Continuity of Care does not apply for services not covered by Medi-Cal, or DME, transportation, other ancillary services, or carved-out service Providers.

If you are a contracted Provider providing services to a Health Plan Member, you may initiate a request for continuity of care through the Provider portal, Medical Authorization Form available on the Health Plan's website at www.hpsj-mvhp.org., or by contacting Customer Service at (209) 942-6320 or (888) 936-7526.

If you are a non-contracted Provider providing services to a Health Plan Member, you may initiate a request for continuity of care by submitting a Medical Authorization Form available on the Health Plan's website at www.hpsj-mvhp.org. or by contacting Customer Service at (209) 942-6320 or (888) 936-7526.

OBTAINING A SECOND OPINION

Health Plan honors the Member's right to obtain a second opinion from another Provider when indicated. To coordinate this, the Member should be directed to an in-network Provider. If an in-network Provider is unavailable, Authorization for an out-of-network second opinion should be requested. The UM Department will notify the Member and the originating Provider in writing of the result of the authorization request and assist with making arrangements for the second opinion upon request.

Health Plan will allow a second opinion to Members by an appropriately qualified healthcare professional, if requested by a Member or a participating Provider who is treating the Member. An authorization is not needed for a second opinion with an in-network Provider. If the Provider is out of network, an authorization is needed. Health Plan will also arrange transportation if needed for the second opinion.

COVERED SERVICES THAT DO NOT NEED PRIOR AUTHORIZATION/REFERRAL

Health Plan permits a Member to obtain some Covered Services without a referral or Prior Authorization. A complete list of these Covered Services can be found on the Provider Portal and should be regularly reviewed for changes.

However, the following Covered Services never need a referral from a Provider. Members may choose an in-network Provider or an out-of-network Provider for:

- Emergency Services
- Certain preventative services (Access the Provider Portal for more information)

- Basic prenatal care in-network
- HIV testing
- Family Planning
- Treatment and diagnosis of sexually transmitted diseases (STDs)
- Sensitive services for both men and women
- Well women health service

STANDING/EXTENDED REFERRALS

Health Plan's Primary Care Providers (PCP) may request a standing or extended access referral to a non-network Specialist for a Member who has ongoing specialty care needs. Health Plan will refer Members to contracted specialists unless there is no specialist within the plan network that is appropriate to provide treatment to the Member, as determined by the primary care physician in consultation with the planned medical director as documented in the treatment plan. When a standing or extended access referral is medically necessary and there is no appropriate network specialist to provide treatment to the Member, the standing or extended referral will be approved to an out of network Specialist for up to 12 months.

Conditions necessitating a standing or extended access referral and/or the development of a treatment plan are interpreted broadly as a "condition or disease that requires specialized medical care over a prolonged period of time and as life threatening, degenerative or disabling" and could include but are not limited to the following:

- Hepatitis C
- Lupus
- HIV/AIDS
- Cancer
- Potential transplant candidates
- Severe and progressive neurological condition
- Renal failure
- Cystic fibrosis
- Acute leukemia
- High risk pregnancy

AFFIRMATIVE STATEMENT ON INCENTIVES

Health Plan's UM decision making is based solely on appropriateness of care, service, and existence of coverage. Health Plan does not specifically reward any Provider or other individuals

for issuing denials of coverage. Financial incentives for UM decisions do not in any way encourage decisions that result in underutilization.

SUBMITTING REQUESTS FOR AUTHORIZATIONS

Providers must verify a Member's eligibility before submitting a referral for Authorization for Covered Services. Eligibility may be verified through the Provider Portal located in the Provider area of the Health Plan website (www.hpsj-mvhp.org). Alternate methods to verify eligibility are detailed in this Manual under "Eligibility Verification, Member Enrollment, and Customer Services." The list of services that require Prior Authorization, and the Authorization Request Form are located in the Provider Portal, and on the Provider page of the Health Plan website.

ADVANTAGES OF SUBMITTING AUTHORIZATIONS ONLINE

Providers can submit referrals online through the Portal or by fax at 209-942-6302. Online is the preferred mode of submission, with the following advantages for Providers:

- Immediate access to the status of the referral (not available for faxed requests)
- Direct communication with Health Plan staff via the Provider Portal regarding any aspect of the Authorization status

The following information is required for Authorization Requests:

- Member's demographic information (name, date of birth, etc.)
- Request type (Office Based or Facility)
- Requester
- Requester affiliation or "Pay to Service"
- Provider's National Provider Identifier (NPI) (only required for paper submissions)
- Provider Group's NPI (if there is a Group NPI; only required for paper submissions)
- Provider's tax ID number (only required for paper submissions)
- Location where services will be provided
- Requested service/procedure, including specific CPT/HCPCS codes and quantity requested
- Member diagnosis (ICD code and description)
- Signature of requesting Provider Modifiers, if applicable
- Fax back number
- Clinical indications necessitating service or referral
- Pertinent medical history and treatment

- Medical records and/or other documents supporting the request
- Supporting clinical documentation (Clinical information can be scanned and uploaded directly into the Provider Portal along with the Authorization request.)

TURNAROUND TIME FOR PRIOR AUTHORIZATION

The turnaround time for a prior Authorization depends on the status of the request:

- **Urgent Request**: Within seventy-two (72) hours of receipt of Authorization request
- **Routine Request:** Within five (5) Working Days of receipt of Authorization request.
- Prompt Authorization determinations are made in accordance with the guidelines when all supporting clinical information that supports medical necessity is submitted along with the Authorization request.

EMERGENCY/URGENT CARE SERVICES

Emergency and Urgent Care Services are available at any time without Authorization. Health Plan does not deny claims for Emergency Services including screening (triage) even when the condition does NOT meet the medical definition of "Emergency Services". Hospitals, urgent care centers, and professional services (including labs, ancillary services, etc.) cannot bill, charge, or collect money from any Member for any Emergency or Urgent Care Services. PCPs should council Members if they are using hospital Emergency Services for routine, non-Emergency medical conditions.

As appropriate, Members should use urgent care facilities for urgent non-Emergency conditions. Health Plan has contracted with urgent care centers throughout the Service Area and they offer both convenient
hours and, in most cases, shorter waiting times than Emergency Rooms.

Observation Stay

Certain Health Plan hospital service agreements contain a provision for an observation stay. An observation stay means a period of up to 24 hours when continuous monitoring, on an out-patient basis, is required to evaluate a Member's medical condition or determine the need for an inpatient admission.

An observation stay is only covered when ordered by a physician and meets medical necessity criteria. No Authorization is required for an observation stay lasting 0-24 hours.

The following is a list of conditions that may be appropriate for an observation stay.

Condition or Symptom	Purpose of Observation
Abdominal Pain	Rule out and manage pain
Chest Pain	Rule out and manage pain
Back Pain	Rule out and manage pain
Syncope	Rule out, stabilize and treat
Seizures	Rule out, stabilize and treat
Fever of unknown origin	Rule out, stabilize and treat
Asthma	Stabilize and treat
Bronchitis	Stabilize and treat
Bronchitis (pediatric only)	Stabilize and treat
Cellulitis	Culture, sensitivity test and plan of care
Concussion	Stabilize and observe
Croup (pediatric only)	Stabilize and treat
Dehydration	Stabilize and treat
Drug overdose	Stabilize, Manage and refer
Gastroenteritis	Stabilize and treat
Migraine headaches	Manage pain
Neurological deficit (pediatric only)	Rule out, stabilize and treat
Phlebitis	Rule out and stabilize
Pneumonia	Rule out and give first dose(s) of agent(s)
Renal colic/calculus	Stabilize and treat
General malaise and fatigue	Rule out, stabilize and treat

INPATIENT ADMISSIONS

All non-emergency (elective) admissions to Acute Care, Acute Rehabilitation, Long-Term Acute Care, and Long-Term Care facilities require Prior Authorization. Providers are also required to admit Members only to Hospitals contracted with Health Plan. Elective admissions to out-of-network facilities will require prior Authorization.

Long-Term Care

Health Plan covers long-term care services for Members who need out-of-home placement in a long-term facility due to their medical condition.

Types of Long-Term Care Facilities

Medi-Cal covered long-term care services include placement in the following types of facilities:

- Nursing Facility Level A (NF-A) and Level B (NF-B)

Effective January1, 2024, or as authorized by the Department of Health Care Services, Health Plan will cover the following additional types of facilities:

- Subacute Care Facilities – both adult and pediatric facilities
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Intermediate Care Facilities for the Developmentally Disabled Habilitative (DD-DH)
- Intermediate Care Facilities for the Developmentally Disabled Nursing (DD-N)

Health Plan coordinates placement in a health care facility that provides the appropriate level of care based on Member's medical needs.

Criteria for Admission

The Medi-Cal long-term care benefit has specific criteria for admission to each type of long-term care facility based upon the Member's diagnosis, physical limitations, and medical treatment needs. If a Provider intends to refer a Health Plan Member to a nursing facility, it is important to understand Medi-Cal's facility-specific criteria. Providers can use the following link to find the long-term care admissions criteria for each type of facility: www.medi-cal.ca.gov

Referring a Member to a Nursing Facility

Here are several important reminders for physicians who intend to refer a Health Plan Member to a nursing facility:

1. To refer a Member to a nursing home, the physician must order the admission and provide the following information:
    a. The Members' medications, diet, activities, and medical treatments, such as wound care and labs.
    b. A current history and physical
    c. Diagnosis/diagnoses
    d. Indication of whether the physician will be following the Member once admitted to the facility
2. In making the referral, the physician must identify the facility of admission. The Member and/or the Member's authorized representative may also seek the physician's counsel in determining an appropriate facility.
3. The admitting facility is responsible for obtaining authorization from Health Plan. The admitting facility will present medical justification for the level of care requested. If the authorization request is not approved or is modified, the Member, physician, or facility has an option to appeal the determination.

Trauma Care

Certain Health Plan contracted hospital service agreements contain a provision for trauma care. The hospital must be a designated trauma facility to receive reimbursement for trauma care.

Trauma care is defined as inpatient or outpatient services provided during one uninterrupted

admission or outpatient service initiated in a hospital emergency department of a Member who is treated directly by the hospital trauma-based care team. The Member's condition must meet the trauma triage protocol adopted by the American College of Surgeons committed on trauma or the hospital's specific emergency medical services criteria.

Trauma activation is defined as an on-site active participation of Members of the trauma team including trauma surgeon, in the care of the Member from admission in the hospital emergency department, in accordance with the applicable triage guidelines and criteria and in response to the pre-arrival notification.

1. The initial evaluation of the Member must take place within 30 minutes of the Member arriving to the emergency department; this evaluation must take place within 8 hours of the traumatic event should the Member be transferred from another facility.

2. The hospital's contracted trauma reimbursement rate will not be paid if the initial evaluation of the Member does not take place within 30 minutes of the Member arriving in the emergency department or within 8 hours of the traumatic event if the Member is transferred from another facility.

3. The activation of the trauma team must be in response to the notification of key hospital personnel by pre-hospital caregivers.

4. A Member who dies prior to arriving at the hospital cannot be charged the trauma team activation rate regardless of whether the pre-hospital caregiver notification was provided to the receiving hospital.

5. A Member who dies within 24 hours of arriving in the Emergency Department can be charged the outpatient trauma rate.

Health Plan requires the following documentation be submitted to the Utilization Management (UM) Department to allow trauma charges:

1. A trauma activation sheet completed at the time of the Emergency Department assessment and documentation submitted.

2. Documentation the nurse triage responded to the patient immediately upon arrival.

3. Documentation that the physician responded with a patient assessment within 15 minutes (Level1) and within 30 minutes (Level 2 and 3).

Trauma triage protocol per local county EMS agency includes the Member meet at least one of the criteria listed below in order for a valid trauma activation and subsequent trauma charge:

1. Anatomic Criteria

a. All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee;
b. Flail chest;
c. Two or more proximal long-bone fractures;
d. Crushed, degloved or mangled extremity;
e. Amputation proximal to wrist and ankle;
f. Pelvic fractures;
g. Open or depressed skull fracture; or
h. Paralysis

2. Physiologic Criteria
    a. Glasgow coma scale (GCS) of < 14;
    b. Systolic blood pressure (SBP) of < 90 mm HG; or
    c. Respiratory rate of < 10 or > 29 breaths per minute (< 20 in infant aged < 1 year)
3. Mechanism Criteria
    a. Falls
        i. Adults: fall > 20 feet (one story = 10 feet)
        ii. Children aged < 15 years: fall 10 feet or two to three times child's height;
    b. High-risk auto crash
        i. Intrusion: > 12 inches to the occupant site or > 18 inches to any site
        ii. Ejection (partial or complete) from automobile
        iii. Death in same passenger compartment
        iv. Vehicle telemetry data consistent with high-risk or injury;
        v. Auto versus pedestrian/bicyclist thrown, run over or with significant (> 20 mph) impact; or
        vi. Motorcycle crash > 20 mph

Administrative Day

Certain Health Plan contracted hospital service agreements contain a provision for administrative days. An administrative day means an authorized inpatient day for a Member who no longer meets medical necessity criteria for inpatient service at an acute care hospital, is unsafe for discharge and is pending placement in a nursing home or other subacute or post-acute care.

Authorization from Health Plan's Utilization Management (UM) Department is required for an administrative day. The inpatient facility requesting the administrative day must submit daily documentation of the Member's condition, type of services received and documented reasonable five (5) attempts of placement efforts in a nursing home or other subacute or post-acute care. The hospital must continue daily placement attempts in a nursing home or subacute or post-acute care during the Member's administrative day stay.

INPATIENT CONCURRENT REVIEW

To ensure quality and cost-effective inpatient care, Members must receive the appropriate level of care while they are in the inpatient setting. Health Plan's goal is a safe, efficient Member discharge transition to the most appropriate and least restrictive setting that meets the Member's needs. Upon admission to an inpatient facility, a Concurrent Review Registered Nurse (CCRN) reviews the facility clinical documentation to ensure the Member is receiving quality care at the appropriate intensity regardless whether the care is delivered in an acute, rehabilitation, skilled, or other inpatient setting. Clinical information should be submitted within 24 hours.

Health Plan's physicians and other licensed clinical staff apply national standards of care (*MCG*) to determine the medical necessity for the inpatient stay and the level of care, namely, acute medical-surgical, telemetry, intermediate or intensive care unit level of care. If the medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the inpatient stay or for the level of care requested, the inpatient stay will be denied by the Medical Director.

The Facility and Provider are provided the reason for the denial and the appeal rights. If the level of care that is delivered to the Member is deemed inappropriate, the level of care billed by a facility is subject to denial.

Health Plan's CCRN leverages a team approach with facility staff to successfully coordinate medical care and plan for post-discharge needs. Updated clinical information which includes facility CM contact information should be submitted daily or as requested. The CCRN or Medical Director may need to contact the Attending Physician to address complex issues or problems that arise.

INITIAL HEALTH APPOINTMENTS

Within one hundred twenty (120) days of the date of Enrollment or change of PCP, PCPs must perform an Initial Health Appointment (IHA) for all Members. For Members less than 18 months of age, IHA must happen within 120 calendar days of enrollment or within periodicity timelines established by the AAP Bright Futures for age 2 and younger, whichever is sooner.

An IHA must be provided in a way that is culturally and linguistically appropriate for the Member and must be documented in the Member's medical record.
An IHA must include ALL of the following:

- A history of the Member's physical and mental health.
- An identification of risks.

- Dental screening and oral health assessments for children under age three (3) years old, including a referral to a dental Provider if needed.
- Immunizations including documentation of all age-appropriate immunizations in the Member's medical record.
- An assessment of need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases.

An IHA is not necessary if the PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.

For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. IHA must include age- appropriate childhood screenings including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

For adults, PCPs should continue to provide all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

ADULT PREVENTIVE GUIDELINES

<table>
<tr><th>Screening Recommendations</th><th>21 to 39</th><th>40 to 49</th><th>50 to 65</th><th>65 and Older</th></tr>
<tr><td>Initial Health Visit</td><td colspan="3">Within 120 days of enrollment</td><td></td></tr>
<tr><td>History and Physical Exam</td><td colspan="3">Every Year</td><td></td></tr>
<tr><td>Blood pressure, Weight, and Height Check</td><td colspan="3">With Every History and Physical</td><td></td></tr>
<tr><td>Alcohol misuse screening and counseling</td><td colspan="3">Recommended</td><td></td></tr>
<tr><td>Drug misuse screening and counseling</td><td colspan="3">Recommended</td><td></td></tr>
<tr><td>Depression Screening</td><td colspan="3">Recommended</td><td></td></tr>
<tr><td>Obesity</td><td colspan="3">Recommended</td><td></td></tr>
<tr><td>Tobacco Use Screening</td><td colspan="3">Recommended</td><td></td></tr>
<tr><td>HIV Infections</td><td colspan="3">Recommended</td><td>If at risk</td></tr>
<tr><td>Syphilis</td><td colspan="4">If at risk</td></tr>
<tr><td>Tuberculosis</td><td colspan="4">If at risk</td></tr>
<tr><td>BRCA Gene Screening</td><td colspan="4">Talk to Doctor about risks (e.g. family history of breast or ovarian cancer)</td></tr>
<tr><td>Chlamydia and Gonorrhea</td><td colspan="4">Consult Doctor</td></tr>
<tr><td>Intimate Partner Violence</td><td colspan="2">Childbearing-aged women</td><td></td><td></td></tr>
<tr><td>Cervical Cancer</td><td colspan="3">Pap smear every 3 years, or every 5 years with HPV co-testing starting at age 30</td><td></td></tr>
<tr><td>Abnormal Glucose/Diabetes</td><td></td><td colspan="3">If overweight or obese</td></tr>
<tr><td>Hepatitis C Screening</td><td colspan="4">If at risk</td></tr>
<tr><td>Colorectal Cancer</td><td></td><td colspan="3">Recommended</td></tr>
<tr><td>Breast Cancer</td><td></td><td colspan="3">Biennial Screening</td></tr>
<tr><td>Lunger Cancer Screening</td><td></td><td></td><td colspan="2">If at risk</td></tr>
<tr><td>Osteoporosis</td><td></td><td colspan="3">If at risk</td></tr>
<tr><td>Abdominal Aortic Aneurysm</td><td></td><td></td><td></td><td>If an “ever smoker”</td></tr>
<tr><th colspan="5">Preventive Therapies</th></tr>
<tr><td>Primary Prevention of Breast Cancer</td><td colspan="4">If at risk</td></tr>
<tr><td>Folic Acid Supplementation</td><td colspan="2">If capable of conceiving</td><td colspan="2"></td></tr>
<tr><td>Statins for Primary Prevention of CVD</td><td colspan="4">If at risk</td></tr>
<tr><td>Aspirin for Primary Prevention of CVD and Colorectal Cancer</td><td></td><td colspan="2">If at risk</td><td></td></tr>
<tr><td>Fall Prevention in Community-dwelling Older Adults</td><td></td><td></td><td colspan="2">If at risk</td></tr>
<tr><th colspan="5">Immunizations</th></tr>
<tr><td>Influenza</td><td colspan="4">One dose annually</td></tr>
<tr><td>Tetanus, diphtheria, pertussis (TDAP)</td><td colspan="4">1 dose Tdap, the Td booster every 10 years</td></tr>
<tr><td>Shingles (Zoster)</td><td></td><td></td><td colspan="2">2 doses</td></tr>
<tr><td>Pneumococcal Polysaccharide</td><td colspan="3"></td><td>1 dose</td></tr>
<tr><td>Pneumococcal Conjugate</td><td colspan="3"></td><td>1 dose</td></tr>
<tr><td>Meningococcal B</td><td colspan="4">If at risk</td></tr>
<tr><td>Meningococcal A, C, W, Y</td><td colspan="4">If at risk</td></tr>
<tr><td>Measles, mumps, rubella (MMR)</td><td colspan="3">1 or 2 doses depending on indication (if born in 1957 or later)</td><td></td></tr>
<tr><td>HPV (Female)</td><td>2 or 3 doses depending on age at initial vaccination 19-26 yrs</td><td></td><td></td><td></td></tr>
<tr><td>HPV (Male)</td><td>2 or 3 doses depending on age at initial vaccination 19 -21 yrs</td><td></td><td></td><td></td></tr>
<tr><td>Chickenpox (Varicella)</td><td>2 doses (if born in 1980 or later)</td><td></td><td></td><td></td></tr>
<tr><td>Hepatitis A</td><td colspan="4">If at risk</td></tr>
<tr><td>Hepatitis B</td><td colspan="4">If at risk</td></tr>
<tr><td>Hepatitis C (HCV)</td><td colspan="4">If at risk</td></tr>
<tr><td>Haemophilus influenza type b (Hib)</td><td colspan="4">If at risk</td></tr>
<tr><th colspan="5">Counseling Recommendations</th></tr>
<tr><td>Sexually Transmitted Infection</td><td colspan="4">If at risk</td></tr>
<tr><td>Diet/Activity for CVD</td><td colspan="4">If at risk</td></tr>
<tr><td>Skin Cancer</td><td>If at risk</td><td></td><td></td><td></td></tr>
<tr><td>Recommended for Women Only</td><td colspan="2">Recommended for Men Only</td><td colspan="2">Recommended for all Adults</td></tr>
</table>

* CVD=Cardiovascular Disease

Sources: USPSTF Recommended Adult Preventive Health Care Schedule Grade A and B 2020, CDC Recommended Adult Immunizations 2020

09032020

ANNUAL COGNITIVE HEALTH ASSESSMENT

In accordance with APL 22-025, Health Plan provides coverage for annual cognitive health assessments for Members who are 65 years of age or older who do not have Medicare coverage.

This assessment may be performed by any licensed health care professional contracted with Health Plan who is enrolled as a Medi-Cal Provider, is acting within their scope of practice, and is eligible to bill Evaluation and Management (E&M) codes.

Contracted Providers must complete the following steps in order to bill and receive reimbursement for these annual assessments:

- Complete the DHCS Dementia Care Aware cognitive health assessment training prior to performing the assessments.
- Administer the assessments as part of E&M visits.
- Create required documentation.
- Use appropriate CPT codes.

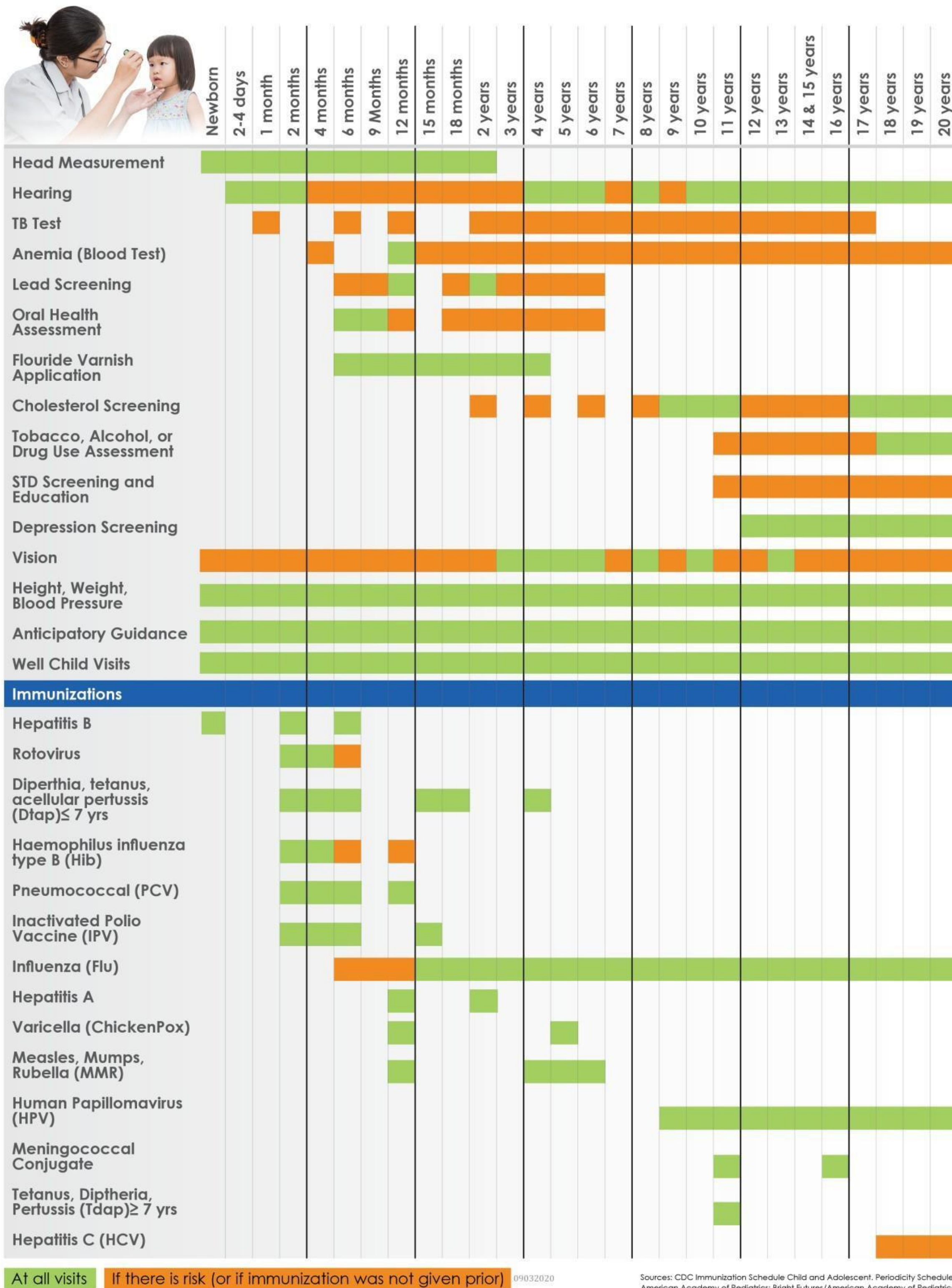
Providers must use at least one of the required cognitive assessment tools:

- General Practitioner Assessment of Cognition (GPCOG)
- Mini-Cog
- Eight-item Informant Interview to Differentiate Aging and Dementia
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Providers are advised to continue to provide assessments, referrals and treatments as needed to Members under 65 years of age who show or report symptoms of cognitive decline.

For questions about the Annual Cognitive Health Assessment, please contact your Provider Relations representative.

PEDIATRIC PREVENTIVE GUIDELINES



BLOOD LEAD SCREENING OF YOUNG CHILDREN

All Providers who perform Periodic Health Assessments (PHAs) on child Members between the ages of six months to six years (i.e. 72 months) must comply with current federal and state laws, and industry guidelines for health care Providers issued by the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB), including any future updates to these guidelines.

Guidelines specific to lead screening are as follows:

1. Provide oral or written anticipatory guidance to the parent(s) or caregiver(s) of a child Member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
2. Order or perform blood lead screening tests. Blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. Testing must be performed on all child Members in accordance with the following:
    a. At 12 months and at 24 months of age.
    b. When the network Provider performing a PHA becomes aware that a child Member who is 12 to 24 months of age has no documented evidence of a blood lead screening test performed at 12 months of age or thereafter.
    c. When the network Provider performing a PHA becomes aware that a child Member who is 24 to 72 months of age has no documented evidence of a blood lead screening test performed.
    d. At any time, a change in circumstances has, in the professional judgement of the network Provider, put the child Member at risk.
    e. If requested by the parent or caregiver.
    f. Laboratories and Providers that perform a blood lead analysis drawn in California must electronically report all blood lead levels, along with the information specified in California Health and Safety Code, Section 124130, to the EBLR System.
3. Follow up must be performed for all positive screening results. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a Provider may determine additional services that fall within the EPSDT benefit are medically necessary. Health Plan will ensure that Members under the age of 21 receive all medically necessary care as required under EPSDT.
4. Reporting timeframe for all blood lead results:

a. Greater than or equal to 10 ug/dl must be reported within 3 working days of analysis.
b. Less than 10 ug/dl must be reported within 30 calendar days of analysis.

Reporting of the blood lead test results to the State go into a system called The Response and Surveillance System for Childhood Lead Exposures (RASSCLE).

Providers may also report directly to San Joaquin County Public Health Services Childhood Lead Poising Prevention Program (CLPPP), by faxing the results to **(209) 953-3632**. Once received via fax and reviewed they will be entered into RASSCLE if they are not, they will send them to the State to be uploaded into RASSCLE.

For more information
Blood Lead Reporting Requirements Website:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx
Blood Lead reporting inquiries: EBLRSupport@cdph.ca.gov or complete the EBLR Contact Form

5. Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

6. Network Providers are not required to perform a blood lead screening test but should clearly document in patient medical record if either of the following applies:

   a. In the professional judgment of the network Provider, the risk of screening poses a greater risk to the child Member's health than the risk of lead poisoning.

   b. If a parent, caregiver, or other person with legal authority chooses to withhold testing, the Provider must obtain and retain a signed statement of voluntary refusal along with the reason for the refusal to consent to the screening. This evidence shall be retained to ensure compliance with Blood Lead Screening requirements.

   c. Follow the current CLPPB issued guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up care. Including additional confirmatory venous testing, referrals, case management and reporting as set forth in the CLPPB guidelines. Additionally, network Providers may determine additional services that fall within the Early and Periodic Screening, Diagnostic and Testing (EPSDT) benefit are medically necessary.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)- CALIFORNIA HEALTH AND DISABILITY PROGRAM (CHDP)

Providers seeing children less than twenty-one (21) years of age must participate in CHDP. CHDP is Medi-Cal's comprehensive and preventive child health program for individuals. Recipients receive periodic health screening exams required by the federal Medicaid "*Early and Periodic Screening, Diagnostic and Treatment"* mandates in California. Corrective treatment resulting from

child health screenings must be arranged even if the service is not available to the rest of populace.

The Health Plan's Utilization Management team will assist Providers in such arrangements. The following minimum elements are included in the periodic health screening assessment:

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

VACCINES FOR CHILDREN (VFC)

The Vaccines for Children Program (VFC) Program is administered through the Centers for Disease and Prevention (CDC) and the National Center for Immunization and Respiratory Diseases. VFC provides vaccines at no cost to children who might not otherwise be vaccinated because of their inability to pay. CDC buys vaccines at a discounted rate and distributes them at no charge to those private physicians' offices and public health clinics registered as VFC Providers. Children enrolled in the Health Plan are eligible for free vaccines. Providers are paid for administering the vaccines. Please see the section in this Manual on "Claims and Billing" for billing instructions. Health Plan's Network Providers must document each member's need for ACIP-recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Appointments (IHAs)
- Pharmacy Services
- Prenatal and postpartum care
- Pre-travel visits
- Sports, school, or work physicals
- Visits to an LHD
- Well patient checkups

Effective January 1, 2023, all California healthcare providers who administer vaccines are to enter immunization information for each patient in the immunization registry(ies) established in Health Plan's service areas as part of the Statewide Immunization Information System within fourteen (14) calendar days, and in accordance with state and federal laws.

Please see the VFC program details at the following link. https://eziz.org/vfc/overview/

- Benefits to Providers
- How to enroll Online https://eziz.org/vfc/enrollment/
- Covered Vaccines
- Who can be a VFC Provider
- Medi-Cal's relationship with VFC

Additional resources:

- VFC Provider Requirements https://eziz.org/vfc/Provider-requirements/
- Provider Enrollment https://eziz.org/vfc/enrollment/
- Immunization Quality Improvement for Providers https://eziz.org/vfc/Provider-requirements/iqip/

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventative Care

Health Plan and its contracted practitioners and Providers must comply with state and federal laws and regulations regarding the provision of Medi-Cal services including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The EPSDT benefit is set forth in the Social Security Act (SSA) Section 1905(r) and Title 42 of the United States Code (USC) Section 1396d. 1, 2. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program.

According to guidance from the Centers for Medicare and Medicaid Services (CMS), titled EPSDT — A Guide for States,

"The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."

"California Welfare and Institutions Code, section 14059.5, subd. (b), defines medically necessary services for individuals under 21 years of age as those services that meet the standards set forth in Section 1396d(r)(5) of Title 42 of The United States Code. Accordingly, a service is considered "medically necessary" or a "medical necessity" if it corrects or ameliorates defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan".

SECTION 8: UTILIZATION MANAGEMENT

Health Plan adopts Preventative Screening Guidelines recommended by The American Academy of Pediatrics, Bright Futures Guidelines, Guidelines for the Pediatric Prevention Care and American Academy of Family Physicians Adult Preventative Guidelines.

Linked and carved out services must be coordinated for the following services when a need is identified:

Behavioral Health

Prior authorization is not required for referral to an in-network BH practitioner. If out of network services are needed for continuity of care or other medically necessary reasons, please submit a prior authorization request. Physician and other medical practitioner offices can refer Members directly to in-network BH practitioners listed in Health Plan's Provider directory, Members can call for appointments directly (they can self- refer) , call Health Plan's Customer Service Department at 1.888.936.PLAN(7526) or assistance or call our MBHO Carelon at 1.888.581.7526 or questions and assistance.

Behavioral Health Treatment or Applied Behavior Analysis for Members under 21

PCP Referral Options:

1. For Members under age 21 that need BHT services for autism: Fax completed PCP Referral Form, Progress Note with MD order for BHT/ABA services with documentation supporting that BHT is medically necessary to (877) 321-1776 or send via secure email to ASGCare.Managers@carelon.com. Include Member consent to allow confirmation of referral process.
2. Call Carelon Service Center at (855) 834-5654 during normal business hours (M-F 8:30 am-5 pm) for any questions or guidance regarding the referral process. Press 2 to bypass the phone tree. Say, "I am calling from a PCP office and requesting a referral for BHT/ABA services for my patient. Also applies to community Providers.

Carelon's Next Steps:

- BHT Services Care Coordinator contacts Member to assist securing resources for services
- Carelon will contact the PCP to confirm completion of referral process

Carelon Behavioral Health of California, Inc./Health Plan of San Joaquin and Mountain Valley Health Plan Primary Care Provider (PCP) Referral Form

Referral Date:______________ Member Name:____ Medi-Cal CIN ID#:____________________________

DOB: ___________________ Parent/Guardian Name:____________________________________ Preferred Language: ___________________________

Phone: ___________________ (home); _____________________________ (parent/guardian's cell); ___________________________ (member's cell)

Member address: ____

Does the minor 12 and older have capacity to give consent to services? ☐ Yes ☐ No If no, please explain ____________________________________

Best day/time to reach the member: ______________________________ Best day and time to reach the parent/guardian: ___________________

PCP Clinic/Agency: ___________________________ Name of PCP: _______________________________ PCP Phone #: _______________________

To receive a confirmation of this referral's outcome, please check the box below noting preferred method and contact details:

☐ Email address: ________________________________ ☐ Fax Number: ___________________________________

☐ **Please check** to confirm member eligibility was verified

PCP Request (one request per referral form)

PCP Decision Support: To obtain a mental health educational conversation with a Carelon Behavioral Health psychiatrist related to psychiatric diagnoses/medications. Contact the National Peer Advisor line: **Office Hours:** 6am-5pm PST Monday – Friday ***Please call phone number:*** 877-241-5575

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Carelon Behavioral Health's network of providers when their needs are outside the PCP scope of practice. Carelon Behavioral Health can coordinate member care with county mental health. *Fax: **877.321.1787** OR secure email: medi-cal.referral@carelon.com*

☐**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD) or for whom BHT/ABA services are medically necessary. **Include Progress Note with physician order requesting ABA services. *Fax: **877.321.1776** OR secure email: ASGCare.Managers@carelon.com*

☐**Referral for Psychological or Neuropsychological testing:** Refer members to psychological/neuropsychological testing via Carelon Behavioral Health's network of providers when their needs are outside the PCP scope of practice. Carelon Behavioral Health can coordinate member care with county mental health. *Fax: **877.321.1787** OR secure email: medi-cal.referral@carelon.com*

Request Reason (check all that apply):

Symptoms:

☐Depression
☐Poor self-care due to mental health
☐Psychosis (auditory/visual hallucinations, delusional)
☐ Adverse Childhood experiences (ACEs)
☐ Perinatal depression/anxiety
☐ Violence/Aggressive behavior
☐ Psychological testing
☐ Neuropsychological testing
☐ PTSD/Trauma
☐ Abuse/CPS
☐ Chronic Pain
☐ Anxiety
☐Substance use type: ____
☐Other BH symptoms: ____

Impairments:

☐Difficult/Unable to complete ADLs ☐Difficulties maintaining relationships ☐Legal/CPS
☐Difficult/Unable to go to work/school ☐Other:_________________________________

Medications (list below or send medication list with this form):

____

Motivation for Services (check all that apply)

☐ Member (or guardian) has been informed for referral to Carelon Behavioral Health
☐ Member wants services for self (or dependent)
☐ Member is unsure or ambivalent about services for self (or dependent)
☐ If applicable, Patient has completed a PHQ-2/PHQ-9, Score ___________

For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.

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DEVELOPMENTAL DISABILITIES SERVICES (DDS)

A developmental disability is a disability which originates before an individual reaches twenty-one
(21) years old, continues or can be expected to continue indefinitely, and which constitutes a substantial disability for that individual. This term includes but is not limited to developmental delay, cerebral palsy, epilepsy, autism, and disabling conditions, but exclude other handicapping conditions that are solely physical in nature.

As part of the initial health assessment and routine health assessment (which will be done according to the American Academy of Pediatrics Periodicity Schedule), the PCP or Specialists must screen and identify individuals with significant developmental delay or those at risk for developmental disability and make the appropriate referral to the appropriate Regional Center and for cognitive delays and behavioral health concerns to Carelon Behavioral Health for evaluation & referral for services. The following information must be included:

- Reason for the referral
- Complete medical history and physical examination, including appropriate developmental screens
- Results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.
- For Members that need care coordination and case management or social needs please refer them to Health Plan’s Case management team at (209) 942-6352 or Health Plan’s Social Work team at (209) 942-6395.

REGIONAL CENTERS

Regional Centers (RC) are nonprofit agencies that have a contract with Department of Developmental Services to provide or coordinate services and support for individuals with developmental disabilities who reside in our covered counties: Alpine, El Dorado, San Joaquin and Stanislaus Counties.

To be eligible for RC services the person must have a disability that begins before the individual’s 18th birthday that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, epilepsy, autism, and other conditions as defined in Section 4512 of the California Welfare and Institutions Code.

Services offered by RCs include:

- Diagnosis and assessment of eligibility
- Access, coordinate and monitor services and supports
- Early Start Therapeutic services
- Adult day centers/program services
- Behavioral Management Services

- Client/Parent Support/Behavior Intervention Training
- Crisis Intervention Facility/Bed
- Crisis Team – Evaluation and Behavioral Intervention
- Day Care Services
- Durable Medical Equipment
- Employment Programs
- Family Home Agency
- Foster Grandparent/Senior Companion Programs
- Health Care Facilities
- Home Health Supports
- Housing Support Services
- Increase Community Access
- Independent Living Services
- Infant Development Services
- Medical Specialists and Professionals
- Mobility Training
- Out-of-home respite services
- Parent Coordinated Services
- Personal Emergency Response System
- Pharmaceutical Services
- Residential Care Homes
- Respite Services – In-home
- Social/Recreational Services and Non-Medical Therapies
- Self-Determination
- Specialized Transportation
- Speech Services
- Supplemental Program Supports
- Supported Living Services
- Therapies
- Translator/Interpreter Services

Resource: https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf

Providers can refer Members to RCs by contacting their corresponding office:

Regional Center	**Office Location(s)**	**Counties Served**
Alta California Regional Center Website: https://www.altaregional.org/	2241 Harvard Street, Suite 100 Sacramento, CA 951815 Phone: 916-978-6400 TTY: 916-489-4241 Early Start Intake: 916-978-6249	Alpine and El Dorado
Valley Mountain Regional Center	San Joaquin Branch:	San Joaquin and Stanislaus

Website: www.vmrc.net	702 N Aurora St. Stockton, CA 95269-2290 Phone: 209-473-0951 TTY: NA Early Start Intake: 209-955-3281 (under age 3) Lanterman Act Services: 209-955-3209 (over age 3)	
	Stanislaus Branch: 1820 Blue Gum Ave. Modesto, CA 95358 Phone: 209-529-2626 Early Start Services: 209-557-5619 Lanterman Act Services: 209-557-2197	

CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS) is a State program for children with certain diseases or health problems. The CCS program provides health care services, including diagnostic, treatment, dental, administrative case management, physical therapy, and occupational therapy services, to children from birth up to twenty-one (21) years of age with CCS-eligible medical conditions. Applicants must meet age, residence, income and medical eligibility requirements to participate in the CCS program. Medically Necessary services to treat a child's CCS-eligible medical condition are "carved out" of HPSJ's financial responsibility. This means that HPSJ is not financially responsible for reimbursing Providers for CCS eligible services.

The CCS program requires authorization for health care services related to a child's CCS-eligible medical condition. Providers must request CCS services to CCS by submitting Service Authorization Requests (SARs) to a CCS county or State office, except in an Emergency. To render CCS-eligible services to a Medi-Cal patient and to receive reimbursement from CCS, any Provider must be CCS paneled and the facility must be a CCS certified facility. During the interim, between the submission for the child to become enrolled in CCS, Providers must continue to provide care to the Member either under capitation or fee-for-service depending upon the Provider's Agreement. CCS is in place to help Providers care for Members with special health care needs. For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov.

Referrals to CCS are accepted from any source, health professionals, parents, legal guardians, school nurses, Health Plan,, etc. Referral forms are available on the Health Plan, Medi-Cal, or CCS websites. The health plan remains responsible for all other required services including preventative services for everything except the CCS eligible services.

Members must be diagnosed with a CCS qualifying condition. CCS eligible conditions include but are not limited to:

- AIDS
- Cancer
- Cataracts
- Cerebral palsy
- Chronic kidney disease
- Cleft lip/palate
- Congenital heart disease
- Diabetes
- Endocrine, Nutritional, and Metabolic Diseases and Immune Disease
- Hearing loss
- Hemophilia
- Intestinal disease
- Infectious Diseases
- Liver disease
- Medical Therapy Program
- Mental Disorders
- Muscular Dystrophy
- Neoplasms
- Prematurity
- Rheumatoid arthritis
- Severe burns
- Severe crooked teeth
- Severe head, brain or spinal cord injuries
- Sickle cell anemia
- Spina bifida
- Thyroid conditions
- Tumors

For a complete list of CCS eligible conditions refer to the CCS website. Providers can refer Members to CCS by contacting the CCS county office at:

San Joaquin County California Children's Services
2233 Grand Canal Blvd Suite 214
Stockton, CA 95207
209-468-3900

Stanislaus County California Children's Services
917 Oakdale Road
Modesto, CA 95355
209-558-7515

Alpine County California Children's Services
75 Diamond Valley Road #B
Markleeville, CA 96120
530-694-2146

El Dorado County California Children's Services
941 Spring Street, Ste. 3
Placerville, CA 95667
530-621-6128

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Children with Special Health Care Needs (CSHCN) are defined by the Department of Health Care Services (DHCS) as: "those who have or are at increased risk for a chronic, physical, behavioral, developmental, or emotional condition and who also require health or related services of a type or amount beyond that required by children generally."

Health Plan is committed to assuring that all Medically Necessary screening, preventative, and therapeutic services are provided to Members with developmental disabilities. PCPs and/or Specialists are responsible for identifying Members with potentially eligible conditions and subsequently referring those Members to appropriate programs for genetically handicapped persons. Members that require evaluation and services for developmental delay should be referred to the appropriate Regional Center (RC) which is the primary referral source for Health Plan's Service Area.

FAMILY PLANNING SERVICES

Members may obtain family planning services from their PCP or a Specialist on Health Plan's panel of Providers without prior Authorization or a referral. Members can also obtain these services by going outside of Health Plan's network to any family planning Provider or Provider of Sensitive Services without a referral or Authorization. This out-of-network provision is without any

restrictions.

SENSITIVE SERVICES FOR ADOLESCENTS AND ADULTS

Sensitive Services are services that require some form of confidentiality in the way services are provided and the way medical records are disclosed for all Medi-Cal Members. These services must be administered with the following guidelines in mind:

- Sensitive Services are provided in confidence to adolescents and adults without barriers (e.g., can't require parental consent)
- Authorization for Sensitive Services is not required
- Adult Members may self-refer without prior Authorization for Sensitive Services except in cases where those services require hospitalization
- Parental consent for children twelve (12) years and older is not required to obtain Sensitive Services
- Providers will not at any time inform parents or legal guardians of a minor's Sensitive Services care and information without minor's permission, except as allowed by law

Health Plan provides access without prior Authorization or referral to any in-network Provider or out- of-network Provider that a Member may select to provide Sensitive Services.

Sensitive Services include but are not limited to consultations, provision of supplies or medical devices, examinations, education, and treatment related to:

- Family Planning
- Pregnancy Testing
- HIV Testing and Counseling
- Sexually Transmitted Diseases
- Elective Abortions
- Behavioral Health Services

AIDS Medi-Cal Waiver Program

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization.

Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their primary care Provider, family, caregivers, and other service Providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution.

The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care.
- Increase coordination among service Providers and eliminate duplication of services.
- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and • Enhance utilization of the program by underserved populations.

Clients eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service Providers.

For further information refer to the Office of AIDS.

FACILITY/ANCILLARY REFERRALS AND AUTHORIZATIONS

Hospital Authorizations

Facility referrals for elective Inpatient Service must be prior Authorized by Health Plan. After the Member is admitted to the facility, the admitting Provider, including any hospitalists, will manage the Member's treatment and care. Admissions to out-of-network facilities require prior authorization approval by Health Plan's UM Department.

Health Plan uses *Milliman Care Guidelines* to determine the medical necessity for the admission, length of stay and treatment options. It is imperative that the Facility team and Health Plan work together for the clinical benefit of the Member, but also for clarity in determining claims payment.

Hospital Emergency Admissions

The Emergency admission of a Member to any Facility must be reported to Health Plan within twenty- four (24) hours for post hospitalization admission. This reporting must be followed with a detailed summary of the Member's clinical condition, options, and prognosis for treatment. This report must clinically demonstrate the need for inpatient treatment. Without this clinical

Health Plan of San Joaquin
Mountain Valley Health Plan

information, Health Plan may deny the admission as not Medically Necessary. Once the clinical information is received and reviewed by Health Plan, the admission may be Authorized denied, or pended for additional information after the first 24 hours of admission. Post stabilization admissions for out of network hospitals will be paid at a DRG rate. Call the UM line for authorization of services 209- 461-2205 prior to admitting to an inpatient stay.

Outpatient and Ancillary Referrals

Providers should consult the Provider Portal for guidance on referrals for outpatient and ancillary services. For Covered Services requiring Authorization, the requesting Provider will be notified of Health Plan's decision to Authorize or deny. Upon Authorization, Health Plan will coordinate with contracted outpatient and/or ancillary Providers. Ancillary services are routinely limited to the Medi-Cal guidelines for ancillary benefits.

Prior Authorization

Health Plan requires all covered services for physical and behavioral health conditions that require authorization, be submitted to the Health Plan's Utilization Management (UM) department for review for medical necessity.

Health Plan's physicians and other licensed clinical staff apply national standards of care MCG to determine the medical necessity for outpatient services. If the requested service is not addressed in the MCG guidelines the Medi-Cal criteria in the Medi-Cal Provider Manual is utilized, If there are no applicable guidelines in both resources, the reviewer will consult Health Plan's internal policies, followed by peer reviewed, published literature to determine the medical necessity for the requested service. If medical necessity criteria is not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, it will be denied by the Medical Director.