MEDI-CAL
*Customer Service

The Customer Service Department is an integral part of the Santé Physicians' commitment to service. This department services three types of customers: Members, Physicians and their office staff/ billing services.

Members
Examples of the role of the Santé Customer Service Department for Medi-Cal members are:

1. To provide members with physician rosters.
2.
3. To assist in claim inquiries, ancillary provider selection, and current physician roster information.
4. To facilitate prompt payment of claim problems.
5. To educate as needed.
6. Redirect eligibility inquiries to member's designated health plan.
7. Redirect PCP assignment inquiries to member's designated health plan.

The Customer Service telephone number for members is listed below.

For:	Call:
Members	(559) 228-4466

Physicians, Office Staff, Billing Services
Examples of the role of the Santé Customer Service Department for physicians, office staff, and billing servic
are:

1. To provide verification of PCP assignment as received from the member's Medi-Cal health plan.
2. To facilitate prompt payment of claim problems.
3. To educate as needed.
4. Redirect eligibility inquiries to member's designated health plan.
5. Redirect PCP assignment inquiries to member's designated health plan.

Customer Service telephone number for Physician Offices is listed below.

For:	Call:
All PCP and Specialty Offices	(559) 228-4466

Patient Billing Statements from Physician Offices or Surcharges

Santé's Managed Medi-Cal contracts authorize patient billings to be limited to the following:

- Non-covered services due to ineligibility

Patient statements are not authorized and should not be sent. Surcharges of any kind are also prohibited. If a physician office is sending patients a statement showing full charges or a surcharge has been imposed, they will be considered out of compliance with both the managed Medi-Cal contract and the Knox-Keene Health Care Service Plan Act.

(Please check eligibility at least 5 days prior to date of service. If you have been notified that a patient is not eligible, you may bill the patient at that time.)

For any claim issue, physician offices should work directly with Santé's Customer Service Department, where our staff is dedicated to working with both PCP and Specialty Physician offices.

Waiver of Liability

Medi-Cal members must be properly informed in advance and in writing of services or procedures that are not covered by their benefit plan. If they choose, have the member sign a waiver agreeing to pay for non-covered services. If the provider does not obtain a signed waiver of liability, and the care is unauthorized by Santé, the provider is expected to accept full liability for the cost of the service or procedure.

(Non-covered services maybe verified with patients health plan)

In the event the member chooses to upgrade a product or service, by signing the waiver the member is agreeing to pay the difference between the billed and allowed amount. If the provider does not obtain a signed waiver of liability, the provider is expected to accept the allowed amount as payment in full.

You may choose to use your own form with similar language. Once signed, this form is to remain in the patient file and it is not necessary to mail to Santé with the claim. Following is an example Waiver of Liability form:

SANTÉ PHYSICIANS

MEDI-CAL
* WAIVER OF LIABILITY FORM

MEMBER NAME: _____ **DOB:** _____

SUBSCRIBER ID: _____ GROUP **NO:** _____
PROVIDER: _____

Provider: This form is to be used for Santé members who wish to receive health care services from you that may not be covered by their Benefit Plan.

Member: Your signature on this form acknowledges that you agree to bear financial responsibility for all services provided as listed below if:

- the service(s) is not covered under your benefit plan, or,
- the service(s) has not been otherwise approved for payment by your health plan, or
- the service(s) is not medically necessary, or
- the service(s) is primarily for comfort and convenience, or,
- You choose to upgrade a product or service above the level otherwise covered under your health plan (you will pay the difference between the billed and allowed amount)

Services: (Any service not described as a covered benefit in the member's Evidence of Coverage Disclosure Form)

Date of Service	Service, Product, or Upgrade	Total Cost	Member's (patient's) Responsibility*

*In addition to being responsible for this amount, I understand that I will be billed and held responsible for any applicable copayment or deductible.

_____
Patient Name

_____ _____
Signature of Patient/Guardian **Date**

_____ _____
Signature of Witness **Date**

MEDI-CAL
* LANGUAGE ASSISTANCE PROGRAM

SB853
Language Assistance Program

The Language Assistance Program is designed to meet the growing needs of our state's population as well as the health membership of each of the plans.

The following is an outline of what the Language Assistance Program entails:

Language Assistance Program

Service Offered	Guidelines
Interpreter services provided at all points of contact	• Professional interpreters are proficient in health care terminology • Professional interpreters receive training regarding HIPPA (confidentiality) and ethical standards • Points of contact include administrative, clinical, and related services
Written materials that are provided in the threshold languages	• Materials translated prospectively include enrollment, eligibility and membership information, EOBs, and notices of language assistance. • Members must indicate their preferred written language to receive prospectively translated materials
Written materials are translated into a threshold language upon request	• Materials that are member-specific (e.g., denial, delay or claims letters) are sent in English with the offer of translation upon request • Translated materials are sent to the member no later than 21 days from the request date • Translators are proficient in health care terminology • Translators received training regarding HIPAA (confidentiality) and ethical standards

MEDI-CAL
* LANGUAGE ASSISTANCE PROGRAM

What is a threshold language?

A threshold language is a language other than English that is spoken by the proportion of the health plan's enrollees. The health plans are required to provide interpretation and translation services for their identified threshold languages at a minimum.

Plan Threshold Languages

Plan	Languages
Anthem Blue Cross	Chinese (traditional), Korean, Spanish, Tagalog, Vietnamese
Health Net	Chinese (traditional), Spanish

Please note: Some plans may provide interpreter services for more languages than their identified threshold languages. Just ask when you call the above numbers.

Accessing Interpreter Services by Plan

Plan	Type of Interpretation	Plan Interpreter Access
Anthem Blue Cross	Telephonic …….	1-800-407-4627
Health Net	Telephonic …….	1-888-893-1569

When utilizing the Health Plan Interpretation Services:

1. Give the customer care associate the member's ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made
4. Once connected to the interpreter, the associate or nurse introduces the member, explains the reason for the call and begins the dialogue.

For Information on Face-to-Face Interpretation services, please inquire with the Health Plans Interpretation Service Line.

MEDI-CAL
* CLAIMS Submission Guidelines

Claim Form
Use of the HCFA -1500 form *(sample follows)* is required to process your claim.

- Indicate the Medi-Cal plan on the top of the claim form;
- Identify the member's name, address, and identification numbers, and/or include a copy of the member's plan identification card;
- Include any other insurance information so that we may coordinate benefits;
- If appropriate, indicate on the claim document if you were providing services for another physician on an "on-call" basis, for proper benefit determination.
- Identify services rendered using CPT codes;
- For injections use J codes, specifying units provided.

Claims Submission Timeline:
Claims must be submitted promptly to avoid the possibility of forfeiture of payment for services. Please note that the Santé Managed Medi-Cal contract specifies if a claim is denied due to late provider claims submission, the charges are not the financial responsibility of the patient.

- Medi-Cal claims must be received within 180 days of the date of service**.**
- For claims in which SP Medi-Cal is secondary, claims must be submitted within 180 days from the "processed date" as noted on the explanation of benefits from the primary carrier.

Submit claims to:

Santé Physicians
(Managed Medi-Cal Plan name here, example: Anthem Medi-Cal)
P.O. Box 45021
Fresno, California 93718

Claims Inquiry
The follow-up process should be initiated if claim notification (payment, denial, or explanation) is not received from Santé within 60 days of initial claim submission:

- PCP and Specialty offices may call the Customer Service Department for claims inquiries at (559) 228-4466.
- Claims inquiry can be made via the Santé web site at www.medi-cal.santehealth.net (office manager or provider access is required.)
- File a Provider Inquiry

Provider Inquiry Request Form

The Provider Inquiry form on the following page may be used to:

- Check status of claim(s)
- Request clarification on calculation of payment
- Submit corrected billing
- Resubmit a contested claim, submitting missing information

Submit Provider Inquiry Request form to:

Santé Managed Medi-Cal
P.O. Box 45021
Fresno, CA 93718 or Fax to: (559) 228- 4465

SANTÉ PHYSICIANS

MEDI-CAL

PROVIDER INQUIRY REQUEST

Send to:
Provider Inquiry
Santé Physicians – Managed Medi-Cal Plans
P.O. Box 45021
Fresno, CA 93718

Sent by: (provider name/facility)	Provider Tax ID #:
Provider Address:	

Patient Name:	Date of Birth:
Member ID Number:	Claim Number (if known):

Service "From – To" Date:	Original Claim Amount Billed:	Original Submission Date:

INDICATE REASON FOR INQUIRY AND PROVIDE A DETAILED DESCRIPTION:

Inquiry Type:

- ☐ Resubmission of "contested" claim with missing information. (documentation attached)
- ☐ Status of Claim (i.e., no receipt of payment)
- ☐ Clarification on calculation of payment
- ☐ Assistance in determining member responsibility

_____ _____ _____
Contact Name (Print) Title Phone Number

_____ _____
Signature Date

MEDI-CAL
* Electronic Claims Submission Guidelines

Submission Guidelines
Claims must be submitted promptly to avoid the possibility of forfeiture of payment for services. Please note that the Santé Managed Medi-Cal contract specifies if a claim is denied due to late provider claims submission, the charges are not the financial responsibility of the patient.

- Claims must be received within 180 days of the date of service**.**

When Santé Medi-Cal is Secondary
For claims in which Santé Medi-Cal is secondary, claims must be submitted with 180 days from the "processed date" as noted on the explanation of benefits for the primary carrier. These claims must be submitted hardcopy on a HCFA- 1500 form with the primary carrier's explanation of benefits.

Santé encourages all paper submitters to submit claims electronically by either using the direct format or through a clearinghouse. You can submit all claims directly to Santé by obtaining an application through our website at www.Medi-Cal.santehealth.net

How to sign up for direct electronic submission with Santé:

- Go to www.Medi-Cal.SanteHealth.net
- Click on the Provider/Administrator link
- Click on Sign Up button
- Select: Use This Link To Print The Office Manager Access Request Form.
- Print the Request Form
- Fill-out and fax Request Form to (559) 228-2958

Santé is partnered with clearing houses including Office Ally, Change Health Care and ENS (Electronic Network Systems) to assist you in billing claims using existing billing software. Contact your clearinghouse to discuss further and provide them the payer ID below.

Payer ID: SNTMC
Claims that require supporting documentation should be sent by mail to the address above.

To submit your claims electronically, please contact Santé's Customer Service at

(559) 228-4466

MEDI-CAL
* Provider Dispute

A provider dispute is a written notice challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted, contested, or seeking resolution of a billing determination or other contract dispute.

Each provider dispute must contain at a minimum the following information:

- The providers name, address and phone number
- Providers identification number
- A clear identification of the disputed item including date of service
- A complete and accurate explanation of the issue
- If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue

Provider disputes for medical inappropriateness will be reviewed by the Medical Director or the Associate Medical Director.

Time Limitations for Submission of Provider Disputes
The physician has 365 calendar days from the date of denial notification to submit a provider dispute.

Provider Dispute Address
Provider disputes must be submitted with a formal written letter explaining the circumstances as to why the denial should be reviewed for reconsideration. The use of the following *Provider Dispute Resolution Request* form may be used in lieu of a letter.

Submit Provider Disputes to:

Attention: Santé Medi-Cal Customer Service/Appeals

Via Mail: P.O. Box 45021, Fresno, CA 93718
Via Physical Delivery: 7370 N. Palm Ave. #101, Fresno, CA 93711
Or
Via Fax: (559) 224-4465

MEDI-CAL
* Provider Dispute

SANTÉ PHYSICIANS

PROVIDER DISPUTE RESOLUTION REQUEST

Send to:
Santé Managed Medi-Cal Customer Service/ Appeals
P.O. Box 45021, Fresno, CA 93718
Or
Fax to: (559) 224-4465

Provider Name:	**Provider Tax ID #:**
Provider Address:	**Contracted?** ☐ **Yes** ☐ **No**

Patient Name:		**Date of Birth:**
Health Plan Name:	**Subscriber ID #:**	**Claim Number:**
Service "From – To" Date:	**Original Billed Amount:**	**Claim Amount Paid:**

Claim Information: ☐ Single Claim ☐ Multiple "LIKE" claims (attach spreadsheet)

Dispute Type: ☐ claim ☐ Appeal of Medical Necessity ☐ Contract Dispute ☐ Seeking Resolution of a Billing Determination ☐ Disputing a Request for Reimbursement of Overpayment ☐ Other

Description of Provider Dispute:

Expected Outcome:

Contact Name (Print) _____ Title _____ Area code & Phone Number _____

Signature and date _____ Email Address _____ Fax Number _____

MEDI-CAL
* Overpayments

Santé's policy on Claims Overpayments is to "take back" overpayments from future charges. Full itemization will be reflected on the remittance advice.

According to California Law, Santé has 365 days from date of payment to recover an overpayment. Santé is not restricted by the 365-day time limit if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

If the provider contests the overpayment "take back", the provider, within 30 business days of the date of the remittance advice, must submit a written notice stating the basis upon which the provider believes that the claim was not overpaid. In this case, Santé treats the claim overpayment dispute as a provider dispute.

Please reference previous page for the *Provider Dispute Resolution Request* form.

MEDI-CAL
* Vaccines for Children (VFC) Program

Billing Guidelines updated 9/7/2018

Santé will not reimburse for the cost of the provider-purchased vaccines that are available through the VFC program and administered to Santé Managed Medi-Cal children through the age of 18 years old, except when justified (ex: documented vaccine shortage, disease epidemic, etc.) A provider's non-enrollment in the VFC program is not a justified exception.

Reminder: The federal VFC program supplies free vaccines to enrolled physicians. Every Medi-Cal-eligible child 18 years of age and under may receive vaccines supplied by the VFC program. To participate, providers must enroll in VFC even if already enrolled with Medi-Cal or the CHDP program. Providers billing VFC procedure codes are reimbursed for **vaccine administration costs only**.

Billing Procedure:

In order to avoid claims processing delays or denial of payment, providers must bill the valid VFC immunization CPT(s) with modifier SL to report the VFC vaccine administration charge. Please do not bill administration CPTs (ex. 90471, 90472, 90640, etc.) in conjunction with the vaccine and modifier SL. Please note, this billing procedure ONLY applies to the administration of VFC vaccines (CPTs listed on the table below)

Vaccines **not** available through VFC should be billed to Santé **without** the SL modifier and with the appropriate administration CPT code.

The following CPT codes are used to bill the administration fee for the vaccines supplied by the VFC program and **require modifier SL** (used for program recipients 18 years of age and younger.)

MEDI-CAL
* Vaccines for Children (VFC) Program

Bill CPT with modifier SL	When administering this VFC vaccine
90620	Meningococcal vaccine serogroup B (Bexsero)
90621	Meningococcal vaccine serogroup B (Trumenba)
90630	Influenza virus vaccine, quadrivalent, split virus, preservative free, for intradermal use
90633	Hepatitis A vaccine/pediatric/adolescent (Vaqta□, Havrix□)
90644	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenza type B vaccine (Hib-MenCY), 4 dose schedule, when administered to children **6 weeks** − 18 months of age, **for intramuscular use**
90647	Haemophilus influenzae b (Hib) vaccine (PedvaxHIB□)
90648	Haemophilus influenza b (Hib) vaccine (ActHIB□)
90649	Human papillomavirus (HPV) vaccine (Gardasil□)
90650	Human papillomavirus (HPV) vaccine, types 16, 18, bivalent, for intramuscular use
90651	Human papillomavirus (HPV) vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58, monovalent, for intramuscular use
90655, 90656	Influenza vaccine (preservative-free Fluzone□)
90657	Influenza vaccine (Fluzone□)
90658	Influenza vaccine (Fluvirin□)
90660	Influenza virus vaccine, live, for intranasal use (FluMist□)
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90680	Rotavirus vaccine, oral (RotaTeq) (3 dose schedule)
90681	Rotavirus vaccine, oral (2 dose schedule)
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, 0.25 ml dosage
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, 0.5 ml dosage
90688	Influenza virus vaccine, quadrivalent, split virus 0.5 ml dosage
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTap-IPV)
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) for intramuscular use (Pentacel)
90700	DTaP Vaccine (Tripedia, Daptacel, Infarix)
90707	MMR Vaccine (MMR II)
90710	MMRV Vaccine (ProQuad)
90713	Inactivated Polio Vaccine (IPOL)
90714	Diphtheria and Tetanus Toxoids adsorbed, preservative free (7 years of age and older) (Decavac)
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), (7 years of age and older) (Boostrix, Adacel)
90716	Varicella Vaccine (Varivax)
90723	DTaP-HepB-IPV Vaccine (Pediarix)
90734	Meningitis Vaccine (Menactra® or Menveo®)
90743	Hepatitis B Vaccine (Recombivax HB)
90744	Hepatitis B Vaccine (Engerix B)
90748	Hepatitis B and H. Influenza b (Hep B-Hib) (Comvax)
90756	Influenza virus vaccine, quadrivalent, subunit, antibiotic free, 0.5 ml dosage

Example of Correct Billing Procedure Qty Billed Amount
90633SL 1 $9.00 <=*Santé will reimburse the admin fee when the vaccine code is billed with -SL*

Example of <u>Incorrect</u> Billing Procedure Qty. Billed Amount
90633SL 1 $9.00
90471 1 $9.00

MEDI-CAL
* Assistant Surgeon Reimbursement

Surgeons are required to utilize Santé contracted providers as surgical assistants. With the exception of emergency surgeries, prior authorization is required if a non-contracted provider must be utilized as a surgical assistant. In addition to prior authorization, the surgeon will explain the Santé *Assistant Surgeon Reimbursement* policy to the prospective assistant and affirm the assistant's adherence to that policy. Non-contracted assistant surgeons will not be permitted to balance bill Santé patients; such unpaid balances will be considered a matter between the surgeon and the surgical assistant. If the Non-contracted assistant surgeon balance bills a Santé Medi-Cal patient, Santé will be obligated to pay the balance of the charges. In this case, reimbursement will be debited from the surgeon's future reimbursements, not to exceed $1000.

Contracted Physician Surgical Assistants shall be reimbursed at a rate of 16% of the allowable surgical units based upon contract type. The patient may not be balanced billed for the difference between billed amount and paid amount.

Contracted non-physician Surgical Assistants, who are not reimbursed by the surgeon as employees, shall be reimbursed at a rate of 8% of the allowable surgical RBRVS units or units based upon contract type. The patient may not be balance billed for the difference between billed amount and paid amount.

Prior authorization is not required for non-physician Surgical Assistants who are reimbursed by the surgeon as employees. However, the surgeon will not bill Santé for the reimbursement of these assistant surgeon fees.

MEDI-CAL
* Assistant Surgeon Reimbursement

Assistant surgeon fees **ARE ALLOWABLE** on the following procedures and do **NOT REQUIRE** prior authorization when utilizing a Santé contracted assistant surgeon:

12018	20955 - 20973	21552-21554	23420-23472	24301
12047	20975	21557 - 21750	23485 - 23491	24320 - 24331
12057	21011-21014	21810	23515	24340 - 24346
14301	21016	21825	23530 - 23532	24360 - 24470
14302*	21034	21931-21933	23550 - 23552	24498
15734	21044 - 21045	21936	23585	24515 - 24516
15738	21047	22100 - 22226	23615 - 23616	24545 - 24546
15750 - 15758	21049	22318 - 22328	23630	24575
15770	21060	22526* - 22905	23660	24579
15830 - 15832	21121 - 21180	21552-21554	23670	24586 - 24587
15841 - 15850	21182 - 21206	21557 - 21750	23680	24615
15922	21209	23000 - 23020	23800 - 23920	24635
15935	21240 - 21247	23035 - 23040	23929	24665 - 24666
15952	21255 - 21275	23071-23073	24006	24685 - 24802*
19260 - 19272	21339	23077 - 23100	24071-24073	24900 - 24931
19302 - 19318	21343 - 21344	23105	24079-24102	24940
19357 - 19369	21347 - 21348	23107 - 23125	24115 - 24116	25071 - 25073
20100	21360 -21395	23145	24125 - 24126	25078 - 25085
20150	21401 - 21408	23150 - 23156	24134	25107
20251*	21422 - 21436	23172 - 23174	24138 - 24140	25119
12018	20955 - 20973	23182 -23220	23420-23472	25126
20692	21445	23332	23485 - 23491	25135 -25145
20696 - 20902	21462 - 21470	23000 - 23020	23515	25151 -25170
20922 -20924	21490 - 21495	23035 - 23040	23530 - 23532	25215
20937 - 20938	21502	23395 - 23412	24149 - 24155	25250 - 25251
25263 - 25265	26372 - 26392	27065 - 27080	27438 - 27472	27687 - 27692
25300 - 25335	26420	27087 - 27091	27479	27698 - 27703
25350 - 25426	26434	27097 - 27100	27486 - 27495	27705

MEDI-CAL

* Assistant Surgeon Reimbursement

25431 - 25444*	26474	27105 - 27170*	27498 - 27499	27709 - 27725
25446 - 25449	26479	27176 - 27181	27506 - 27507	27727
25490 - 25492	26483 - 26485	27187	27511 - 27514	27740 - 27745
25515	26492 - 26494	27202-27218*	27519	27756 - 27759
25525 - 25526	26497 - 26499*	27226 - 27228	27524	27814
25545	26502*	27236	27535	27822 - 27823
25574 - 25575	26517 - 26518	27244	27536	27826 - 27829
25607 - 25609	26530 - 26531	27245	27540	27832
25628	26541	27248	27556 - 27558	27846 - 27848
25645	26546	27253 - 27254	27566	27870 - 27881
25670	26550 - 26565	27258 - 27259	27580 - 27592	27888*
25676	26568 - 26590	27267 - 27269	27598 - 27599	27894
25685	26596	27280 - 27299	27602	28039
25695 - 25830*	26686	27303 - 27306	27612	28047*
25905-25915*	26820	27310	27620 - 27626	28086
25922 - 25924	26842 - 26844	27325	27632- 27634	28100 - 28107
25929	26852	27326	27637 - 27638	28114
26111 - 26113	26862-26862*	27329	27645 - 27647	28118
26118	27001 - 27006	27331 - 27339	27650	28122
26125*	27030 - 27036	27345 - 27365	27654 - 27659	28130
26185	27045	27380 - 27390*	27665 - 27676	28171
26260-26262	27048 - 27049	27392 - 27415	27685	28202
26352	27052 - 27054	27418 - 27424	27438 - 27472	27814
26357 - 26358	27059	27427 - 27435	27479	27822 - 27823
28210*	30160	33300 - 33417	37660	42961
28238	30410	33422 - 33502	37761	42971 - 42972
28250 - 28260	30430 - 30462*	33504 - 33530*	37788	43020 - 43135
28262 - 28264	30540 - 30545	33533 - 33960	38100 - 38129	43279 - 43415
28289	31075 - 31087	33970	38204	43425
28292 - 28306	31205 - 31230	33973	38207-38215*	43496

MEDI-CAL

* Assistant Surgeon Reimbursement

28308	31295 - 31296	33975 - 34451	38308 - 38382	43500 - 43659
28320 - 28322	31300	34501 - 35206	38530 - 38542	43753-43757*
28360	31360 - 31420	35211 - 35390	38555 - 38780	43770 - 43775*
28415-28420*	31580	35450 - 35458	38900	43800 - 43888
28445 - 28446	31584 - 31595	35500 - 35539	39000 - 39220	44005 - 44055*
28555	31601	35556 - 35681*	39499 - 39599	44110-44310*
28585	31611	35685 - 35870	40701 - 40702	44314 - 44322
28615	31634	35876 - 36000*	40799	44345 - 44346
28705 - 28740	31750 - 31786*	36147-36148*	40840	44602 - 44721
28760 - 28800	31805	36261	40843-40844*****	44800 - 44900
29804	32035 - 32200	36460	42120	44950 - 44979
29820 - 29828	32215 - 32320	36818 - 36821	42200 - 42260	45110 - 45136
29834 - 29837	32440 - 32540	36825 - 36833	42299	45160 - 45172
29843 - 29845	32553	36838	42409 - 42440	45395 - 45499
29847	32561 - 32562	37145 - 37181	42507-42508*	45540 - 45825
29851 - 29863	32650 - 32940*****	37207	42510	46705
29884 - 29885	32998	37216*	42699	46710 - 46751
29887 - 29892	33020 - 33141	37600 - 37606	42725	46760 - 46762
29894-28499*	33243	37615 - 37619*****	42810-42815*	47010
29904 - 29916	33250 - 33261*****	33300 - 33417	42844 - 42845	42961
30125*	32265 - 33266	33422 - 33502	42890 - 42894	42971 - 42972
47015 - 47381	51040	55535*	59350	62192
47400 - 47480	51050 - 51060	55550 - 55559	59514	62200
47550	51080	55650*	59525	62220 - 62223
47562 - 47620	51500 - 51597	55706 - 55845	59620	62230
47700	51800 - 51992	55862 - 55866	59866 - 59870	62256 - 62258
47711 - 47900	53085	56620 - 56700	59898 - 59899	62351
48000 - 48100	53210	56800 - 56810	60200 - 60281*	63001 - 63308
48105 - 48155	53215	57106 - 57130	60500-60699*	63620-63621*

MEDI-CAL

* Assistant Surgeon Reimbursement

50010	54522 - 54560	58672 - 58770	61630 - 61708	64792*
50045 - 50075	54650	58805 - 58822	61711	64802 - 64818
50081 - 50135	54680 - 54690	58825 - 58960*	61796-61800*	64835 - 64840
50205 - 50380	54699	58974-58976*	61850 - 61880	64857 - 64911
50400 - 50549	55150	59070*	62005 - 62147	65105 - 65114*
50562	55400*	59074 - 59121	62161 - 62164	65260 - 65265*
50593 - 50660	55520	59136 - 59151	62180*	65710 - 65756
50700 - 50949	51040	55535*	59350	62192
51020	51050 - 51060	55550 - 55559	59514	62200
65770	67121*	67973 -67974	69670	
65781	67255	68720 - 68750	69711*	
65900	67340*	69155	69725 - 69745	
66165 - 66220	67399	69320	69805	
67027	67413 - 67414	69530	69820 - 69840	
67036 - 67043	67420 - 67450*	69550 - 69554	69915	
67107 - 67108	67570 - 67599	69605	69950 - 69979	
67112 - 67113	67121*	67973 -67974	69670	

Assistant surgeon fees **ARE ALLOWABLE** on the following procedures and do **NOT REQUIRE** prior authorization when utilizing a Santé contracted assistant surgeon:

Prior authorization is **REQUIRED** to utilize an assistant surgeon for procedures **NOT** on the above list. Determination for authorization will be based on the surgeon's documented complexity of the individual case.

MEDI-CAL
* Third Party Liability

Contracted physicians may not refuse to see an assigned Medi-Cal patient who may have been in a motor vehicle accident (MVA), or other Third Party Liability (TPL) injury (excluding workers' compensation). Additionally:

- The physician should always follow Santé policies and procedures (authorizations, referrals, plan providers) to ensure coverage if the TPL denies coverage.
- At no time should a Medi-Cal patient be billed full charges, and only when appropriate should a patient be billed copay.

This policy is in line with contractual, legal and regulatory requirements.

Physicians who are paid fee for service for some or all services rendered to a Santé Medi-Cal patient have the following options:

■ Physician may bill TPL only

- Physician may get more reimbursement from the TPL carrier than from Santé
- If TPL denies coverage, Santé must be billed, not the patient. Include the TPL denial letter to avoid untimely filing denial by Santé.

■ Physician may bill Santé only, supplying Santé with TPL information and indicating *TPL NOT BILLED* on claim form

- Physician will be reimbursed by Santé. No additional money will be paid to physician if Santé collects from TPL carrier.

MEDI-CAL
* California Children Services (CCS)

California Children Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize payment for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services (DHCS) manages the CCS program which is administered as a partnership with the county health department. CCS-eligible patients should be referred to CCS for case management and authorization of treatments.

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of $40,000 or less as reported as the adjusted gross income on the state tax form; or
- the out-of-pocket medical expenses for a child who qualifies are expected to be more than 20% of family income.

CCS covered conditions
In general CCS covers medical conditions that are physically disabling, or require medical, surgical, or rehabilitative services. There may also be certain criteria that determine eligibility. For a complete list of medical conditions visit www.dhcs.ca.gov/services/ccs

CCS claims processing
CCS case related claims must be billed directly to California Children Services for processing. Claims not related to a CCS case may be billed to Santé Managed Medi-Cal within 180 days from the date of the denial notice from CCS. Please ensure the denial notice is submitted with the claim.

MEDI-CAL
* MANAGED CARE COORDINATORS

The Utilization Management (UM) Department has Managed Care Coordinators whose role is to provide utilization information (referrals, prior authorization, benefit determination, etc.), and to serve as principal staff support for medical offices. Telephone calls should be directed to a Managed Care Coordinator as shown below.

The UM department representatives work with physician office staff only. If a patient has a question regarding prior authorization or referrals, please give them the phone number of the Santé Managed Medi-Cal Customer Service Department (559) 228-4466. These two departments work closely on patient issues.

UM Department Main Line (559) 228-4488

MANAGED CARE COORDINATOR	TELEPHONE NO.
Aziz Tohme	559-228-4289
RoseAnn Florez	559-228-4380

MEDI-CAL
* CASE MANAGEMENT

Contact persons:	Telephone:	Fax:
Chameka Howell, R.N., Certified Case Manager	559-228-5313	559-224-2405

Case Management

The purpose of the Case Management program is to ensure that medically necessary care is delivered in a high-quality, cost-effective setting for members who require extensive or ongoing services. Case Managers coordinate individual services for members whose needs include ongoing medical care, home health, hospice care, rehabilitation services and preventative services. To meet identified member's needs, case managers work with all members of the healthcare team including physician, patient, and family members.

Community Case Management

Community Case Management is a community-based model that assists identified members with healthcare needs. Members of all ages are followed by a specific case manager who plans and coordinates the member's care throughout the healthcare continuum. The Community Case Manager, using a "team approach," acts as a consultant and advocate for members served. The goal is to maintain the member on their wellness path. Members who may benefit include members with:

- Chronic condition/illness
- Chronic/ reoccurring medical problems
- Multiple hospital admissions/ER visits
- Functional or emotional impairment
- Frail elderly
- Poor support system at home
- Potential for complications due to multiple health/social problems.
- High risk pregnancy

Referral to Case Managers

Physicians or physician offices are encouraged to refer patients who fit the description of members requiring case managers. Contact persons are listed above.

MEDI-CAL
* REFERRALS – POLICY GUIDELINES

Primary Care Physicians (PCPs) act as managers of their patients' health and are responsible for ensuring that their patients in need of medical care beyond their scope of practice are referred to appropriate Specialist Physicians, designated services or providers. Referral forms are to be used by PCPs when directing patients to these providers. (Note: radiology services do not require a Referral Form. See prior authorization guidelines for some procedures.)

- Note: This policy will not apply in situations where patients are seen on an emergent basis or when utilizing one of the self-referring options.

Referral Process

1. A referral form template is provided to each PCP office to refer Santé Medi-Cal members to a specialist. The PCP may use the template provided by Santé or use his/her own referral form. If the PCP opts to use his/her own referral form, the referral form must contain, at a minimum, all information contained in the Santé referral form template. Additionally, specialist offices may not impose a practice specific referral form to replace the approved referral form template.

    - **NOTE: Effective January 1, 2008, within 5 days before the actual date of service, providers *must* confirm that the member's health plan coverage is still in effect.**

2. Complete a referral form in its entirety when referring to an in-plan physician specialist, designated service or provider. (Do not complete a referral form for routine services, such as x-rays or lab work.)
   Specialist Providers must contact the PCP to send the referral for Specialty services/providers

3. Referrals must include dates, diagnoses and diagnosis codes. Specify "Consult Only" if you wish the specialist to consult with you before treating the patient. Otherwise, mark the number of visits you wish to authorize during the 180-day referral period *.
4. Fax or mail a copy of the referral form to the Specialist Provider, as well as a copy to Santé **within two working days**. Santé's mailing address is P.O. Box 45021, Fresno, California, 93718. The Fax number is (559) 228-4465.

NOTES:

Please contact Utilization Management for authorization of any non-plan provider. This ensures benefit compliance, use of contracted facilities, and negotiation of rates. DO NOT FILL OUT A REFERRAL FORM to a non-plan provider. This will obligate Santé to pay in full, and the referring physician will be monetarily penalized. (See Authorizations)

MEDI-CAL
* Retro Referrals

Retro Referrals are referrals written after the date of service. The Utilization Management Committee has directed that Retro Referrals will be deemed invalid and claims for these services will be denied. (It should be noted that all denials may be appealed.)

Specialty Physicians should require that each patient they see have a valid referral from the patient's Primary Care Physician at the time they are seen. If the patient is seen on an urgent basis or presents himself/herself without a valid referral, Specialty Physicians should immediately contact the Primary Care Physician to receive a valid referral.

A fax copy of a valid referral is acceptable proof that a referral was issued. When the specialist's office contacts the Primary Care Physician's office, the specialist's office should obtain the name of the person with whom they spoke and the control number of the referral, which the Primary Care Physician's office has committed to send. In a situation where a fax copy is unavailable, the control number of the referral may be submitted with the billing for the service rendered.

The above policy will not apply in situations where patients are seen on an emergent basis, or when utilizing one of the self-referring policies in a plan provider's office.

MEDI-CAL
* Global Care Referrals

A Primary Care Physician may refer to a specialist for "global" care, effective for six months care (or as specified below) without limitations on number of visits allowed, for ONLY the following types of care:

NOTE: See self-referral section for patient options.

1. "Global Oncology," to a hematologist/oncologist or a radiologist/oncologist ONLY for ongoing chemotherapy or radiation therapy for malignancy.

2. "Global Allergy Treatment," to an allergist ONLY for allergy immunotherapy or desensitization by injection.

3. Dialysis.

4. “Obesity Management Program,” to a weight management specialist ONLY (see page 703.1). Please include ICD9 code 278.01 on all referrals to this program.

5. “HIV/AIDS”, to a HIV/AIDS specialist.

In this case, the PCP should leave the number of visits on the referral blank and specify the type of care and the diagnosis. However, the specialist must communicate with the Primary Care Physician, and the PCP must concur with the treatment plan.

If the Primary Care Physician wishes the number of visits to be limited, he/she must indicate the number of visits desired.

MEDI-CAL
* Routine Eye Examination Policy

Retro Referrals are referrals written after the date of service. The Utilization Management Committee has directed that Retro Referrals will be deemed invalid and claims for these services will be denied. (It should be noted that all denials may be appealed.)

Specialty Physicians should require that each patient they see have a valid referral from the patient's Primary Care Physician at the time they are seen. If the patient is seen on an urgent basis or presents himself/herself without a valid referral, Specialty Physicians should immediately contact the Primary Care Physician to receive a valid referral.

A fax copy of a valid referral is acceptable proof that a referral was issued. When the specialist's office contacts the Primary Care Physician's office, the specialist's office should obtain the name of the person with whom they spoke and the control number of the referral, which the Primary Care Physician's office has committed to send. In a situation where a fax copy is unavailable, the control number of the referral may be submitted with the billing for the service rendered.

The above policy will not apply in situations where patients are seen on an emergent basis, or when utilizing one of the self-referring policies in a plan provider's office.

MEDI-CAL
* Unauthorized Referrals to Non-Plan Providers

Non-authorized elective services rendered by a non-plan provider, as a result of a Santé contracted physician referral, shall be approved for payment according to the following protocol:

- Services will be paid to the non-plan provider at 100% of Medi-Cal Rates.
- The referring Santé physician's future reimbursements will be debited the amount equal to the difference between payment made to the non-plan provider and the Santé contract reimbursement rate, not to exceed $1000 for each unauthorized referral.

Note: Self-referral option is the only exception.

MEDI-CAL
* Self-referrals – OB/GYN

A Medi-Cal female member has the option of seeking obstetrical and gynecological physician services directly from a Santé OB/GYN or from a participating family practice physician, surgeon, or internist designated as providing OB/GYN services. Additionally, self-referral patient information must be communicated back to the patient's PCP of record. This includes:

- OB/GYN preventive care
- Pregnancy
- Gynecological complaint

OB/GYNs and other specialists treating a Santé Medi-Cal patient under this policy must remember to mark SELF-REFERRAL in box 19 of your HCFA form in lieu of submitting a Santé referral number and form.

MEDI-CAL
* Behavioral Health Referrals

A referral from the Primary Care Physician is not necessary for members to access services. The provider office can direct the member to contact the behavioral health administrators at the following numbers:
(Please keep in mind that the PCP may also contact the administrator)

The County Department of Mental Health
(559) 600-9180

Health Net (Managed Health Network - MHN)
1-888-426-0030

Anthem Blue Cross Medi-Cal (Carve Out)
1-888-831-2246

MEDI-CAL
* PRIOR AUTHORIZATION GUIDLINES

Selected services require prior authorization in order to:

- ensure benefit compliance, use of contracted providers and review of medical necessity;
- provide timely involvement of Medi-Cal corporate resources;
- allow contracting of rates when using non-plan providers.

Please request services as soon as ordered by the physician in order to allow adequate time for the authorization process. All routine authorizations should be submitted by fax. *See sample and master fax form.*

Do not schedule appointments prior to authorization approval. Elective services must be requested a minimum of 48 hours or two full working days prior to scheduled service. If the requesting physician determines that the patient's medical condition requires emergent medical service, the provider must ensure the patient receives timely service and then proceed with the authorization process. However, should review of the information determine that the service was not medically indicated and authorization would not have been given, the service will be denied and the contracted provider(s) must write off all services.

Please note that, from time to time, the Santé Utilization Management Committee will require prior authorization for services other than those listed on the Prior Authorization Form. Pre-authorization requirements may vary by provider or specialty. The Santé Utilization Management Committee will notify you of these requirements.

Prior Authorization Fax Number
559-228-4521

Prior Authorization Not Obtained

Claims for non-emergent services that require prior authorization which are rendered by contracted providers without prior authorization will be denied. Such services will not be the liability of the member. These determinations are subject to appeal.

MEDI-CAL
* PRIOR AUTHORIZATION GUIDLINES

Services Requiring Prior Authorization

* Aqua Therapy
* Breastfeeding Medicine Referral
* Balance & Dizziness Referral
* Colonoscopy; EGD
* Cosmetic/Reconstructive Surgery
* Durable Medical Equipment purchases over $200 (Per line item)
* Durable Medical Equipment (All rentals, regardless of cost)
* Endocrinologist Visit (Type ll Diabetes)
* Genetic Testing
* Home Health / Home IV
* Intensity Modulator Radiation Therapy (IMRT)
* Infusions – Ambulatory
* Injections: Self–Injectables; in-office Injectables listed on back of authorization form
* M2A Video Capsule Endoscopy
* MRI, MRA, CT and Pet scans
* Nutrition Consult for Chronic Disease (CMC)
* Obesity – Referral to General Surgeon
* Obesity Surgery
* Out of Plan Provider
* Plastic Surgery Referral
* Sleep Studies
* Transplants (In conjunction with Health Plan programs)
* Weight Management Program Referral
* Wound Care – Facility Based

NOTE: Emergency services never require prior authorization and will be reviewed retrospectively.

MEDI-CAL
* Emergency Room Authorization

When possible, Medi-Cal members should call their Primary Care Physician for urgent care needs or before seeking emergency services. The Primary Care Physician may refer the member to his/her office, another PCP, an in-plan specialist, or to a Santé contracted emergency room facility, as the situation requires.

Medically necessary emergency services cannot be denied for lack of authorization. Services are to be considered an emergency if; "…in the judgment of any prudent layperson the absence of immediate medical attention could reasonably be expected to result in one of the following, placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any body, organ or part."

GENERAL CRITERIA	
Time of Day (in conjunction with condition severity)	• Before 0800, or after 1700 weekdays • Services during standard working hours, if PCP referral • Week-end or holidays

Condition	• Acute (<6 hours), Sudden (<24 hours), severe onset
	  • Condition or symptoms are life-threatening or have significant potential for chronic disability; i.e., a reasonable person would believe it was life-threatening or disabling
	  • Symptoms developed during non-office hours, despite duration (e.g., over weekend/holiday time), and patient has not been seen within the past 12 months for this same diagnosis or condition

L&D Checks	• Approved

MEDI-CAL
* Emergency Room Authorization

Examples of non-emergent conditions more appropriately treated in office or Urgent Care (unless associated with unstable vital signs or physical findings as above):

- Allergic reactions without dyspnea
- Animal bites that do not require suturing
- Asthma responding to single inhalation or parenteral treatment
- Back pain without recent acute trauma or associated recent neurological complaints or findings
- Bronchitis
- Checks and rechecks of burns, casts, test results or wounds
- Colds or cold sores
- Conjunctivitis without presence of contact lens, foreign body or trauma
- Cough
- Dermatitis, itching, rash
- Diarrhea without bleeding or dehydration in older children and adults
- Dressing change
- Extremity injury without deformity or injury (might be appropriate for urgent care if level of pain requires rule-out fracture)
- Flu symptoms
- Foley catheter replacement
- Genital discharge or pain without abdominal pain
- Headache unless sudden onset, unprecedented severity or associated with fever or recent trauma
- Human bites without tissue disruption
- Ingrown toenails
- Insect bites with only local symptoms
- Lacerations that do not involve nerves or tendons, do not require suturing or are more than 24 hours old
- Localized infections
- Medications administration or refills
- Musculoskeletal pain not associated with recent trauma
- Needle sticks or puncture wounds
- Otitis media unless associated with a temp>103 or ear drainage
- Routine administration of parenteral medications
- Paronychia
- Sinusitis
- Sore throat
- Sty
- Suture removal
- Toothache without facial swelling or lymphadenopathy
- Urinary burning, frequency or infection

MEDI-CAL
* Hospital Observation Status

Patients who have been evaluated either in a physician's office or in an emergency room and found to be too ill to be sent home should be admitted to the hospital and not listed on observation status.

Santé Physicians has established the following policy:

> *Patients admitted directly to the hospital will always be listed under ADMIT status. Patients considered to be unstable for discharge but observed outside the emergency room will be admitted as inpatients and NOT listed on observation status.*

MEDI-CAL
* Criteria used to authorize, modify or deny

When a prior authorization request is authorized, modified, or denied a copy of guideline, protocol or other similar criteria, on which the decision was based, can be requested, by calling Santé Managed Medi-Cal at (559) 228-4466 or at the following Health Plans websites:

Anthem Blue Cross
https://www.anthem.com/wps/portal/ca/culdesac?content_path=provider/f1/s0/t0/pw_a111722.htm&rootLevel=0&name=onlinepolicies&label=Overview

Health Net
https://www.healthnet.com/portal/provider/content/iwc/provider/unprotected/working_with_HN/content/medical_policies.action

MEDI-CAL
* APPEALS - CLINICAL

When a prior authorization request is denied, the physicians or members have the opportunity to appeal the decision. This form of denial is known as prospective denial, one that is given prior to service rendered.

UM appeals must address the reason given for denial for services requested.

Common UM Denials

1. Cosmetic
2. Not a plan benefit
3. Inadequate medical justification
4. Services can be provided by an in-plan provider
5. Alternate service recommended
6. Does not comply with UM guidelines

Submission of Appeals

For all plans, providers or members are to contact the Medi-Cal corporate office directly to submit an appeal. Use the mailing address or telephone number listed in the body of the Santé denial letter. Be sure to include additional information for authorization reconsideration.

To request an appeal by telephone or in writing contact the Health Plan at the following locations:

	Anthem Blue Cross	Health Net
Phone	Contact Anthem Blue Cross between 7 a.m. and 7 p.m. Pacific time Monday through Friday by calling 1-800-407-4627. Or, if you cannot hear or speak well, please call 1-888-757-6034	Contact CalViva Health 24 hours a day, 7 days a week by calling 1-888-893-1569. Or, if you cannot hear or speak well, please call TTY: 711.
Mail	Anthem Blue Cross Attn: Grievance Coordinator P.O. Box 60007 Los Angeles, CA 90060-0007	In writing: Fill out an appeal form or write a letter and send it to: Medi-Cal Appeals Unit P.O. Box 419086 Rancho Cordova, CA 95741-9086
Electronic		Visit your health plan's website. Go to provider.healthnet.com