Regal Medical Group, INC. Lakeside Community Healthcare™ ADOC Medical Group

California Provider & Medi-Cal Program Review

Attention Network Provider,

Below & attached please find summary reviews for these important California and Medi-Cal programs and services. These summaries are providing just an overview of these services and requirements that you must be aware of. To review and learn more regarding any and all of these program requirements, please go onto www.regalmed.com (see Provider tab), or call our Provider Assistance Line at 866-654-3471 and ask for Network Management To reach the on-call staff member after hours, call 818-654-3400; Option 2.

SPECIAL BENEFITS AND COMPLIANCE WHAT YOU NEED TO KNOW

- Preventive Services:
  - Initial Health Assessment (IHA) /Individual Health Education Behavior Assessment (IHEBA)/ Staying Healthy Assessment (SHA)
- Coordinated Services:
  - Durable Medical Equipment (DME)
  - Transportation Services
  - Continuity of Care (COC) Services
  - Managed Long Term and Support Services (MLTSS)
- Services that DO NOT Require Prior Authorization
  - Medi-Cal Sensitive Services
- Carve Out Services
  - California Children's Services Program (CCS)
  - Transplant Procedures
  - Dental Services
  - Vision Services
- Mental Health/Behavioral Health
  - Mental/Behavioral Health Services
  - Behavioral Health Treatment Services (BHT) (Carve-Out) – CA CMD 43
- Medi-Cal Palliative Care Service/End Of Life **
  - Eligibility Criteria
  - Disease-Specific Eligibility Criteria:
  - Medi-Cal Coverage requirements for End of Life Services

*** Newly added 2022*

PREVENTIVE SERVICES

Initial Health Assessment (IHA) /Individual Health Education Behavior Assessment (IHEBA)/ Staying Healthy Assessment (SHA)

Initial Health Assessments (IHA) are a requirement for all new Medi-Cal patients. To make it easy for you, we send out a letter to all your new patients who need their IHA completed. Please note: Patients who are 18 months or older must receive an IHA within 120 days and patients less than 18 months old must receive an IHA within 60 days.

Please refer to our policy and procedure(s) below for detailed information on assessments by age group.

Policy UM 068 - Initial Health Assessment

Policy UM – 030 EPSDT/ CHDP

COORDINATED SERVICES

Durable Medical Equipment

Medi-Cal patients are provided durable medical equipment if medically necessary. Medi-Cal covers medically necessary equipment when it "is appropriate for use in or out of the patient's home" (Title 22, CCR, and Section 51160). For manual wheelchair prescriptions, an evaluation is required by a licensed provider before a manual wheelchair can be ordered.

What You Need to Do:
Visit www.regalmed.com under Provider Resources or within REA under Medi-Cal & News links for sample evaluation form and complete the authorization/claims process for durable medical equipment.

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Transportation Services	Regal may authorize transportation for Medi-Cal patients if the services will allow smooth continuity of care for the patient at Regal's discretion. Please note that transportation services are coordinated differently by health plan. *What You Need to Do:* Submit an authorization request, which must be accompanied by transportation prescription at www.regalmed.com under the Provider Section and our internal case management team will coordinate all transportation requests.
Continuity of Care (COC) Services	For all Medi-Cal patients transitioning to Medi-Cal Managed Care from Medi-Cal Fee For Service (FFS), patients are allowed the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible beneficiaries may require continuity of care for services they had been receiving through Medi-Cal FFS. *What You Need to Know:* 1. Regal must be able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider); 2. The provider must be willing to accept Medi-Cal FFS rates; 3. The provider must meet Regal's applicable professional standards and has no disqualifying quality of care issues. *For more information, call the provider assistance line at 888.787.1712.* ***Please refer to our policy and procedure(s) below for detailed information*** *Policy UM – 043 Continuity of Care*

*** Newly added 2022*

Managed Long Term and Support Services (MLTSS)

Long Term Services and Support (LTSS) help elderly individuals and/or individuals with disabilities with their daily needs for assistance/improvement of their quality of life. Examples include assistance with bathing, dressing and other basic activities of daily living and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS is provided over an extended period, predominantly in the patient's home and in the community, but also in facility- based settings such as nursing facilities.

These services are categorized into four groups:

1. Multipurpose Senior Services Program (MSSP)
2. In Home Support Services (IHSS)
3. Community-Based Adult Services (CBAS)
4. Long Term Care

How to Coordinate Services:

Please visit **www.regalmed.com** for the details of the coordination of LTSS services. For assistance in coordinating care for Medi-Cal patients, provider may send an authorization request. Our Case Management Department will help with the coordination of service.

*** Newly added 2022*

Prior Authorization NOT Required

Medi-Cal Sensitive Services	Medi-Cal Sensitive Services are a covered benefit and do not require prior Authorization for both in and out of network provider services. The list of Medi- Cal sensitive services are as follows: 1. Sexually transmitted diseases 2. Family planning services for network or out of plan providers 3. Abortion services (physician provided services) 4. Sterilization and Informed consent 5. Human Immunodeficiency virus (HIV) Testing and Counseling 6. Minor Consent Services 7. Hospice Services *What You Need to Know:* By law, sterilization requests do not require authorization, but require an informed consent form be obtained from patient and patient be provided with mandated informational booklet. Therefore, all sterilization claims must be accompanied by the sterilization consent form dated and signed by both the provider and the patient 30 days prior to the date the sterilization service was rendered.

*** Newly added 2022*

Carve Out Services

California Children's Services Program (CCS)

California Children's Services (CCS) is a state funded Medi-Cal program for children who are under 21 years of age and meet established criteria. Once a Medi-Cal patient's condition is accepted as a CCS eligible diagnosis, services are carved out to the CCS program by Regal's Medi-Cal CCS department.

Criteria to qualify for CCS services:

- Patient must have a health problem that is covered by CCS
- Patient must be a resident of California and has one of the following:
  - Family income of $40,000 or less
  - Out-of-pocket medical expenses expected to be more than 20 percent of family's adjusted gross income
  - A need for an evaluation to find out if there is a health problem covered by CCS
  - Was adopted with a known health problem that is covered by CCS
  - A need for the Medical Therapy Program Medi-Cal, with full benefits

What to Know and How to Access More Information:

All CCS procedures must be administered by a CCS Panel provider. All CCS referrals should be accompanied by detailed progress/visit notes and also Lab results if applicable to ensure the successful approval of the CCS request. A list of qualifying CCS diagnoses is available at www.regalmed.com under

Transplant Services

Transplant procedures are a covered benefit for Medi-Cal patients. Transplant requests are categorized in two ways based on the payer of the services:

- Kidney and corneal transplants
- All other major organ transplants

Regal evaluates all potential transplant authorization from the provider once the authorization is approved:

For kidney and corneal transplants, the patient's medical group will pay for the services and for all other major organ transplants, the Medi-Cal program pays for the services. This means that all patients who are approved for a major organ transplant except kidney and cornea get reassigned (dis-enrolled) back to the
Medi-Cal fee for service program after evaluation and approval of transplant services.

Please note: The transplant center physician must submit a Treatment Authorization Request (TAR) to the San Francisco Medi-Cal Field Office (For adults 21 years and older) to initiate the reassignment of the potential transplant patient back to the Medi-Cal program. Once the Medi-Cal program approves the request, the transplant center physician can perform transplant services.

San Francisco Medi-Cal Field Office
185 Berry Street, Suite 290
San Francisco, CA 94107
(415) 904-9600
For children under 21 years of age, Regal will coordinate the approval of the TAR with California Children's Services Program.

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Transplant Services (Cont.)	*<u>What You Need to Know</u>* All transplant procedures and Workup needs to be completed at a DHCS approved transplant center. Regal will coordinate all referrals and authorization to ensure this. See the Medi-Cal Transplant FAQ for complete details of the coordination of transplant services at **www.regalmed.com** under Provider Resources or within REA under Medi-Cal & News links.
Dental Services	Dental Benefits are carved out to Denti-Cal with the state. Refer patients to the Denti-Cal program by calling: 1-800-322-6384 for more information.
Vision Services	Vision services are provided by the patient's Health Plan. *<u>We recommend that the patient contact his/her health plan for coordination of services. Health plan name is located on the patient's Medi-Cal ID card.</u>*

Mental Health/Behavioral Health

Mental/Behavioral Health Services

Medi-Cal beneficiaries with serious mental health needs that cannot be met within a primary care physician's scope of practice receive specialty mental health services and support that are administered by the County Health Office or sometimes carved out vendors through the health plan.

How to Refer Patients:
It is best to refer all cases to our Behavioral Health Team by submitting an authorization at **www.regalmed.com**, using your provider access express account.

Behavioral Health Treatment Services (BHT) (Carve-Out) –CA CMD 43

Behavioral Health Treatment (BHT) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement or through prompting to teach each step of targeted behavior. BHT services are designed to be delivered primarily in the home and in other community settings.

Behavioral Health Treatment (BHT) (Cont.)	*BHT services are a Medi-Cal covered benefit for members under 21 years of age when medically necessary, based upon the recommendation of a licensed physician,* *Surgeon or a licensed psychologist after a diagnosis of autism spectrum disorder (ASD).* Please refer to our policy and procedure(s) below for detailed information ***Policy UM-014 Applied Behavioral Health Analysis***

*** Newly added 2022*

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Medi-Cal Palliative Care Service/End of Life

Palliative Care Services (Senate Bill (SB) 1004; Welfare and Institutions Code (WIC) Section 14132.75. WIC Section 14132.75; APL 18-020 Palliative Care):

Palliative care consists of patient-and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care. Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care.

A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

Groups will provide Palliative Care services to eligible Medi-Cal members, where delegated, or, carve it out to health plans if it is health plans responsibility.

Members who needs Palliative Care services are identified by using

- General Eligibility Criteria,
- Disease-Specific Eligibility Criteria
- Pediatric Palliative Care Eligibility Criteria.

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Palliative Care Services (Cont.)	When a member meets the minimum eligibility criteria for Palliative Care, Groups must authorize Palliative Care without regard to age. Palliative Care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions: 1. Advance Care Planning 2. Palliative Care Assessment & Consultation 3. Plan of Care 4. Palliative Care Team 5. Care Coordination 6. Pain and Symptom Management 7. Mental Health and Medical Social Services *Please refer to Policy and Procedure below for further details.* Policy UM-024 Medi-Cal Palliative Care
End of Life (EOL) Services (Carve Out) (DHCS APL 16-006)	Terminally ill members, age 18 or older with the capacity to make medical decisions are permitted to request & receive prescriptions for aid-in-dying medications if certain conditions are met. Provision of these services by health care providers is voluntary and refusal to provide these services will not place any physician at risk for civil, criminal or professional penalties. End of Life Services include consultations and the prescription of an aid-in-dying drug. EOL services are carved out for Medi-Cal Managed Care Health Plans (MCPs) and are covered by Medi-Cal FFS. Members are responsible for

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End of Life (EOL) Services (Cont.)	finding a Medi-Cal FFS Physician for all aspects of the EOL Benefit. During an unrelated visit with an MCP physician, a member may provide an oral request for EOL services. If the physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that physician may elect to become the members attending physician as he or she proceeds through the steps in obtaining EOL services. EOL services following the initial visit are no longer the responsibility of the MCP, and must be completed by a Medi-Cal FFS attending physician, or a Medi-Cal FFS consulting physician. Alternatively, if the MCP physician is not a Medi-Cal FFS provider, the physician may document the oral request in his or her medical records as part of the visit. MCP physician should advise the member that following the initial visit he or she must select a Medi-Cal FFS physician in order for all of the remaining requirements to be satisfied. *Please refer to Policy and Procedure below for further details*. Policy – UM-041 End of Life Option Act

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