MEDICAL SERVICES INITIATIVE (MSI) PROVIDER MANUAL

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HEALTH CARE AGENCY
MSI
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Web Site
www.ochealthinfo.com/medical/msi/providers/news.htm

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APPENDICES

I. INTRODUCTION

The Orange County Medical Services Initiative (MSI) program began in January 1983 as a result of the transfer of responsibility from the State to the County for a category of patients no longer eligible for Medi-Cal. MSI covers necessary medical care for Orange County eligible residents 21 through 64 years of age who have no other resource for medical care.

The MSI program structure includes the County and private medical community in a unique public-private partnership to deliver health care to indigents utilizing the entire medical system and resources. Hospitals are represented by the Hospital Association of Southern California, physicians are represented by the Orange County Medical Association, and community clinics are represented by the Coalition of Orange County Community Clinics in the planning, design and operation of the Program. MSI funded staff are available in each of these organizations to assist providers with administrative issues.

The MSI program publishes and distributes a newsletter that presents updated information on pertinent issues. If you are not receiving the MSI Newsletter and would like to, call MSI Program Support at (714) 834-6248, and ask that your name and e-mail address be added to the distribution list. Otherwise, a copy is always posted online in the provider section of MSI's website located at: *www.ochealthinfo.com/medical/msi/providers/newsletter/.*

MSI has posters and patient handbooks available in English, Spanish, and Vietnamese languages. Copies of the MSI posters and handbooks may be obtained by calling MSI Program Support at (714) 834-6248. Representatives from the MSI program are available for consultation and training workshops.

MISSION STATEMENT

The mission of the Medical Services Initiative (MSI) Program is to serve Orange County's health care safety-net for uninsured, low-income adults by providing timely and quality access to primary, preventive, and specialty services through a public-private partnership between the Orange County Health Care Agency and community health care providers using evidenced based medicine.

Important Information Regarding Expanded Benefits

Beginning September 1, 2007, the MSI program expanded its benefit program as a result of SB 1448 which brought new funding from the federal government. This expansion is expected to continue over the next three years thru MSI's fiscal year 2009-2010. The expanded benefits will include primary and preventive medicine such as regular physicals, mammograms, age-appropriate immunizations, and other

types of laboratory and diagnostic services. In addition, this new program will give MSI members access to an assigned primary care physician or clinic that will serve as their “medical home” (PCP) for all of their general healthcare needs.

The **HIGHLIGHTED AREAS** in this Provider Manual reflect the additional services and/or requirements as a result of the new federal funding. It is important to know that these added services are made possible by the availability of this new funding, which may be reduced or discontinued at any time if federal funding is no longer available.

The federal funds also make it possible for the MSI program to enroll persons who do not have a current medical need who would not otherwise be eligible. These persons may lose their eligibility at any time if federal funding is no longer available, however the goal of this program is to maintain some level of sustainability through cost savings in other areas.

MSI members are reminded to use hospital emergency rooms for emergency conditions only. The hospital has the right to charge MSI members a $25 co-pay for use of their emergency room. MSI members should use their medical home/primary care physician (PCP) for all of their general healthcare needs. If a member is not satisfied with their medical home, they will be permitted to change it once every 30 days.

Each new member will receive an I.D. card with a unique identification number to help them and to also let providers know that they are part of the new MSI. Important numbers are available to the patient such as a 24-hour Nurse Line, the Patient Education Department, the Eligibility Department, and the RxBin number to allow pharmacies to know the patient is in network. A sample of this I.D. card is located in Appendix G-1.

MSI PROGRAM REIMBURSEMENT
DEPENDS ON COMPLIANCE WITH STATE REQUIREMENTS

Hospitals contracted with the County to provide services to the MSI population must comply with the following Welfare and Institutions (W & I) Code sections:

1. 14134.1
   a. *No provider under this chapter may deny care or services on account of the individual's inability to pay a co-payment, as defined in Section 14134. The requirements of this Section shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the co-payment."*

2. 16804.1
   a. *"No fee or charge shall be required of any person before a county renders medically necessary services to persons entitled to services pursuant to Section 17000."*

   b. *"This section is declaratory of existing law and shall not be interpreted to effect a county's authority to implement a reasonable sliding fee schedule based on ability to pay."*

3. 16818
   a. *"Each facility treating persons pursuant to Section 17000 shall provide at the time treatment is sought, individual notice of the availability of reduced cost health care. In addition, conspicuous posted notices of the procedures for applying for reduced cost health care shall be displayed in all emergency rooms and patient waiting rooms of each facility treating persons pursuant to Section 17000."*

   b. *"This Section is declaratory of existing law and shall not be interpreted to constitute a new mandate."*

INFORMATION SOURCES

MSI Patient Eligibility On-line Verification *www.ocmsipov.com*

MSI Program Patient/Provider Relations/Fraud and Recovery P. O. Box 355 Santa Ana, CA 92702	**Providers Only** **Patients Only**	(714) 834-3557 (714) 834-5211 or (866) 613-5178
Advanced Medical Management (AMM) (Fiscal Intermediary) Attention: MSI Program P. O. Box 30248 Long Beach, CA 90853		(800) 206-6591
Physician Services, Inc. (Recovery Agent) 210 South Juniper Street, Suite 200 Escondido, CA 92025		(760) 738-6600
Social Services Agency (SSA) Eligibility Information Line		(866) 979-6772
Orange County Foundation for Medical Care (OCFMC) Utilization Management Department (UMD)	**Main Number**	(714) 634-5169
Hospital Association of Southern California (HASC) 12361 Lewis Street, Suite #101 Garden Grove, CA 92840		(714) 750-0788
Orange County Medical Association (OCMA)		(714) 978-1160
Coalition of Orange County Community Clinics (COCCC) 17701 Cowan Avenue, Suite 220 Irvine, CA 92614-6057		(949) 486-0458
MSI Nurseline–24/7 Healthcare Counseling Information (Provided by Nursing Personnel) Care Management Unit (CMU)		(877) 402-7111 (800) 417-4262 (option 2)
Patient Appeals Department (PAD)		(800) 206-6591
Patient Education Department (PED)		(800) 417-4262 (option 1)

II. PROGRAM SERVICES

A. Medical Homes

A Medical Home is intended to go beyond that of a PCP, providing continuity and integration of health care. The goal of a Medical Home is to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives at the primary care level.

When adults have a medical home, it has been shown that their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. As a result of the Coverage Initiative, all MSI patients are assigned to one of over 170 Medical Homes throughout the County. Most community clinics and many private general practitioners participate in this network. An updated list of participating Medical Homes is located on the provider website at: *www.ochealthinfo.com/medical/msi/providers/news.htm.* If you would like to participate as a Medical Home where a panel of patients can be assigned to you, please contact the Administrator at (714) 834-6249. Providers participating in this program will be included in a bonus pool of additional funds ($250,000) that will be distributed to all Medical Homes based on pay-for-performance measures at the end of each fiscal year. If you would like more detail on these measures, please contact the MSI Administrator at (714) 834-6249.

a. Medical Home Protocol

i. In order to participate as a Medical Home, the provider must be credentialed with the MSI Program once every two years. If the provider is not credentialed or needs to recredential, the provider must go to the following website to complete the process: *https://ochca.amm.cc/register.aspx.*

ii. The MSI Program requires notification in writing—via mail or email—from providers requesting participation or withdrawal as a Medical Home. Email notices can be sent to the Administrator at *dcastillo@ochca.com.* A provider or group can generally be added as a Medical Home within 72 hours once credentialing has been completed.

iii. Should a Medical Home provider want to close their panel of patients (i.e. limit the number of patients assigned to his/her practice), written notification must be received and reasonable time given for the MSI Program to accommodate the provider's request.

iv. Should a Medical Home provider want to discontinue as a Medical Home and have their full panel of patients reassigned to another Medical Home, the provider must submit a written notice to the MSI Program and allow for a 30-day period in which all patients can be appropriately reassigned. Until the reassignment process is fully completed, the provider must continue to coordinate care to those assigned patients.

b. Co-pay Information

i. Only Medical Homes may charge an MSI patient a $5 co-pay under the following circumstances:

1. The patient knowingly visits a Medical Home that is NOT their assigned Home.

ii. Under no circumstances is a Medical Home to charge an MSI patient beyond the $5 co-pay.

iii. Specialists may not impose any charge on an MSI patient with exception of the optional $25 co-pay for emergency department visits.

B. Specialist Referral Assistance

The MSI program's Utilization Management Department (UMD) is in place to assist the Medical Home in obtaining specialists. The process is as follows:

- The Medical Home completes and faxes the MSI Referral Form (available on the MSI provider website at: *www.ochealthinfo.com/medical/msi/providers/news.htm)* to UMD; telephone (714) 634-5169 – fax (714) 634-9655 to request a specialist. If request is sent via fax, send ***only*** pertinent information. If the documentation is lengthy, please call first to discuss the case.
- UMD staff evaluates the MSI Referral Form to determine if it meets Program criteria for medical necessity.
- If approved, UMD staff selects an in-network specialist and sends the Medical Home the MSI Referral Form that includes the specialist's contact information and a ***tracking*** number. The tracking number should accompany the specialist's claim. (*Note:* The tracking number is not a guarantee of payment. For example, a claim may be denied if not filed timely or if the patient becomes ineligible for any reason.
- The Medical Home informs the patient of an authorized referral (including name/phone number of specialist), and advises him/her to schedule an appointment.

Note: **It is important to know that it may take up to three business days for UMD staff to coordinate a request. Unauthorized specialty services may be denied.**

C. Out-Patient Prior Precertification

UMD staff will provide a tracking number for a variety of services including surgery and diagnostic procedures. Ancillary services such as lab and diagnostic procedures do not require a tracking number unless the service includes higher cost items such as nuclear testing, CT, MRI, EEG, cardiac testing, invasive imaging, or Holter monitoring.

D. In-Patient and Skilled Nursing Precertification

UMD staff will provide a tracking number for approved in-patient stays. Unauthorized days may be denied.

E. Process for Denial/Appeal

- UMD staff sends a letter of denial and/or request for additional information to the requesting physician.
- If additional information is not received or does not meet Program scope, a letter of denial is sent to the physician with an explanation for the denial. (*Note:* Appeals must be returned within 30 days).

Note: Physicians may request a second level of review if dissatisfied with determination. The request is directed to the MSI program's Medical Review Committee which meets monthly.

F. Electronic Census Reporting System

Hospitals currently under contract with the MSI program must report all admissions of MSI patients within 24 hours. To streamline this process and save both time and money, MSI has contracted with eCEDA Technologies (eCEDA). eCEDA specializes in medical management applications. This system captures daily census data on both MSI pending and eligible patients and allows our Utilization Managers to know when a patient has been admitted and their current status within the hospital. ***Unless otherwise notified by the MSI program in writing, hospitals must continue to communicate with MSI Utilization Managers via paper or telephone.***

III. OUTPATIENT SERVICES

A. Laboratory

The following providers are contracted with the MSI program for outpatient laboratory services:

- Quest Diagnostics (formerly known as Unilab) and Primex.

Note: **Other laboratories are permitted to contract and provide services as long as they agree to MSI electronic reporting requirements.**

Note: **To find a Quest Diagnostics facility in your area, please contact their information line at (800) 377-8448; select option 2 and enter a zip code.**

The following laboratory services do not meet the purpose of the MSI program:

- Tests related to investigational treatments.
- Fertility, paternity and pregnancy tests.

- FSH, LH, and Estrogen levels to determine status of menopause.
- Routine HIV Test–***HIV test may be covered if symptomatology is documented.***
- Genetic typing to determine risk factors for disease–***Genetic typing may be covered if disease is suspected and typing necessary to confirm diagnosis and/or determine treatment.***
- Mental health related tests including blood levels for psychotropic medications.
- Preoperative tests for surgical procedures not covered under the MSI program. ***Refer to the MSI Provider Manual for more information about covered and non-covered surgical procedures.***
- Tests not related to documented diagnoses.

B. Urgent Care Centers

The following providers are contracted with the MSI program for urgent care services:

- Minute Clinic – Located in select CVS pharmacies throughout Orange County.

  For more information call (866) 389-2727 or visit their website at

  www.minuteclinic.com.

ANAHEIM

- Gateway Urgent Care
  1303 North Euclid St.
  (714) 778-3838
  Monday – Friday: 8 a.m.–10 p.m.
  Saturday & Sunday: 9 a.m.–5 p.m.

BUENA PARK

- Caceras Medical Group
  8585 Knott Ave., #101
  Buena Park, CA 90620
  (714) 821-8588
  Monday – Friday: 8 a.m. – 5 p.m.
  Saturday: 8 a.m. – 12 p.m.

HUNTINGTON BEACH

- Huntington Beach Urgent Care
  17752 Beach Blvd., Suite 203
  Huntington Beach, CA 92647
  (714) 841-1040
  Monday – Friday: 8 a.m. – 8 p.m.
  Saturday – Sunday: 9 a.m. – 6 p.m.

SAN JUAN CAPISTRANO

- Partners In Health
  32241 Camino Capistrano, Suite A-105
  (949) 661-6555
  Monday – Friday: 8 a.m. – 5 p.m.
  (no weekend hours)

IV. GENERAL ELIGIBILITY

The Medical Services Initiative (MSI) program covers medical care to Orange County's eligible residents 21 through 64 years of age who have no other resource for medical care.

A. Eligibility

Eligibility for the MSI program is determined by the Orange County Social Services Agency (SSA). Proof of Orange County residency, citizenship, and a photo I.D. are required for application. Financial information regarding current income must also be provided and verified. Once the application is completed by a Certified MSI Application Taker (CMAT), the forms are forwarded to SSA for review and processing. Information on the application is verified through various automated databases and provided documentation.

Acceptable Citizenship and Identity Documents

The easiest way for U.S. citizens or nationals to provide both proof of citizenship and identity is with one of these documents:

- U.S. Passport issued without limitation (expired ones are ¬acceptable)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of U.S. Citizenship (N-560 or N-561)

OR – If you do not have one of the documents above, then provide

One citizenship document AND One identity document from the lists on the following page

(*Note:* Expired identity documents are acceptable proofs of identity)

Citizenship Documents

1. U.S. Birth Certificate
2. Certification of Report of Birth (DS-1350)
3. Report of Birth Abroad of a U.S. Citizen (FS-240)
4. State Department Certification of Birth (FS-545 or DS-1350)
5. U.S. Citizen Identification Card (I-197 or I-179)
6. American Indian Card (I-872)
7. Northern Marianas Card (I-873)
8. Final adoption decree showing a U.S. place of birth
9. Proof of employment by the U.S. civil service before June 1, 1976
10. U.S. military service record that shows a U.S. place of birth
11. U.S. hospital record established at the time of the person's birth *
12. Life, health, or other insurance record *
13. Federal or State census record that shows the applicant's age and U.S. citizenship or place of birth
14. Seneca Indian tribal census record *
15. Bureau of Indian Affairs tribal census record of the Navajo Indians *
16. U.S. State Vital Statistics birth registration notification*
17. An amended U.S. public birth record (amended more than 5 years after the person's birth) *
18. Statement signed by doctor or midwife present at the time of birth *
19. Admission papers from a nursing or skilled care facility, or other institution that shows a U.S. place of birth
20. Medical record (not an immunization record) *

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* Must be dated at least 5 years before your first MSI application and show a U.S. place of birth. You must provide a document as high on the list as you can.

Identity Documents

1. Driver's license issued by a U.S. State or Territory with a photograph or other identifying information
2. School Identification card with a photograph
3. U.S. Military I.D. card or draft record

4. Federal, state or local government I.D. card with same identifying information as a driver's license
5. U.S. Military dependent identification card
6. A U.S. passport (issued with limitation)
7. Certificate of Degree of Indian Blood or other U.S. American Indian/Alaska Native Tribal document
8. U.S. Coast Guard Merchant Mariner Card

If you cannot provide any of the citizenship documents listed above, the applicant may ask two adults to fill out and sign an ***Affidavit of Citizenship.*** Both adults must have proof of their own identity and U.S. citizenship, and only one of them may be related to you.

Obtaining a Birth Certificate in Person:

Under law, individuals appearing in person will be permitted to receive an authorized copy after presenting a valid government form of identification and signing a statement sworn under penalty of perjury that the requester is an authorized person. Those who are not authorized by law to receive an authorized certified copy will receive a certified copy marked INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY.

Vital record (birth, marriage, and death records) are located in Room 106 of the Hall of Finance and Records in Santa Ana. Office hours are Monday through Friday, from 8 a.m. to 4:30 p.m. Payment can be made by cash, personal check, cashier's check, money order, or ATM/Debit card (additional $2.50 terminal usage fee).

Obtaining a Birth Certificate by Mail:

A copy of a birth certificate can be obtained by mail if the birth occurred in Orange County, unless there has been an adoption or a legal name change. Certified copies are $17 each and orders are normally processed within 5 to 10 working days. Applications submitted by mail must also include a statement, sworn under penalty of perjury, that the requester is an authorized person. It must also be notarized. Applications are available online. Use a separate application form for each record you are requesting.

PLEASE NOTE: Only one notarized sworn statement is required for multiple certificates requested at the same time; however, the sworn statement must include the name of each individual whose record you wish to obtain and your relationship to that individual. Those who are not authorized by law (visit *www.ocrecorder.com/OrderGuide.Asp* to see who is authorized) to receive an authorized certified copy will receive a certified copy marked "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY."

Mail requests to:
Orange County Clerk-Recorder
Attn: Vital Records
12 Civic Center Plaza, Room 106
Santa Ana, CA 92701
Make checks payable to: Orange County Clerk-Recorder

Obtaining a Birth Certificate by Telephone

You may place your request by telephone with VitalChek, a private independent company. Acceptable methods of payment through VitalChek are MasterCard, VISA, American Express or Discover. A $12.95 special handling fee collected by VitalChek will be charged on all credit card orders, in addition to the County of Orange certified copy fee.

Telephone orders will be processed within 5 working days of receipt of the Certificate of Identity. Telephone orders will be returned by regular mail unless Federal Express delivery is requested, which costs an additional $17.50. To place a telephone order or for additional information, please call VitalChek toll free at (877) 445-8988.

Obtaining a Birth Certificate by Fax

For those in need of a quick turnaround time, you may fax your request to VitalChek, a private independent company, at (866) 559-9609. Acceptable payment methods through VitalChek are Master Card, VISA, American Express or Discover. A $12.95 special handling fee collected by VitalChek will be charged on all credit card orders in addition to the County of Orange certified copy fee. For additional information, please call toll free (877) 445-8988.

Fax credit card orders will be processed within 5 working days of receipt of the Certificate of Identity. Fax orders will be returned by regular mail unless Federal Express delivery is requested, which costs an additional $17.50.

If you do not supply the necessary Certificate of Identity within 5 business days, your fax order will be cancelled and must be resubmitted.

For additional information, please call toll free (877) 445-8988.

Obtaining a Birth Certificate Over the Internet

For those in need of fast turnaround time, you may place your request over the Internet with VitalChek, a private independent company. Acceptable methods of payment through VitalChek are Master Card, VISA, American Express or Discover. A $12.95 special handling fee collected by VitalChek will be charged on all credit card orders, in addition to the County of Orange certified copy fee. Internet credit card orders will be processed within 5 working days of receipt of the Certificate of Identity. Internet orders will be returned by

regular mail unless Federal Express delivery is requested, which costs an additional $17.50. For additional information, please call toll free (877) 445-8988. **To place a request over the internet, please have the applicant visit:** *www.vitalchek.com/agency_locator.aspx?providerid=16250.*

Financial eligibility is based upon criteria stated in Title 22 of the California Code of Regulations as it relates to Medi-Cal eligibility with an income cap at 200% of the Federal Income Guidelines. The guideline is updated April of each year.

Appendix F discusses the differences between the Medi-Cal and MSI Programs.

B. Eligibility Determination Process

If a patient does not have financial resources to pay for necessary medical services, he or she may be eligible to apply for the MSI program. After initial screening, the patient is given information about the MSI program and advised to contact a CMAT (Appendix E) at a contracted hospital or community clinic to schedule an appointment to complete an MSI application. The patient must complete the application before SSA can determine eligibility. Appendix C details the referral procedure.

After the CMAT completes the application, SSA must receive it no later than the last day of the third month following the month of service to be covered.

MSI applicants are informed via their Rights and Responsibilities form provided during the application process, of their responsibility to notify medical providers of their eligibility in a timely manner.

An MSI Provider On-Line Verification (POV) system is available 24 hours, 7 days a week for verification of patient eligibility. To access this system, go to *www.ocmsipov.com.* Providers need to input the patient's SSN or member ID, DOB, and the provider's tax ID number. This information is updated daily to ensure the most current information is available. This automated system will provide the following eligibility determinations: Eligible (with period of eligibility), Discontinued Eligibility (eligibility discontinued with date of discontinuance – services are not payable from the date of discontinuance forward), Pending (application still in process), Temporary Eligibility (eligibility granted for a 30-day period only) and Suspended Eligibility (eligibility on temporary hold and claims not payable until case investigation is complete. In addition, the POV site will provide you with the patient's assigned Medical Home. If the patient is denied eligibility, the automated system will not recognize the patient information. It is highly recommended to verify the patient's eligibility and Medical Home each time he/she presents for service.

Applicants who fail to complete the application process are responsible for medical costs incurred. Patients must reapply every twelve (12) months to continue eligibility.

C. Appeals

Eligibility Appeals

Applicants or recipients may request an appeal on any County SSA action or inaction pertaining to their MSI application or eligibility determination process.

The request for a hearing must be filed with the Orange County Social Services Agency Appeals Unit, P.O. Box 22001, Santa Ana, CA 92701-22001. Requests must be filed in writing within thirty (30) days of the date on the Notice of Action. The County is solely responsible for conducting these hearings.

D. Dual Application

Applications for both Medi-Cal and MSI are taken when an applicant is identified as potentially disabled for at least one year. MSI may be approved pending the disability decision by the Disability and Adult Programs Division (DAPD).

If the applicant fails to cooperate in the Medi-Cal application process, an initial MSI application may be approved, but subsequent MSI applications may be denied until the applicant cooperates with the Medi-Cal application process.

E. MSI Eligibles with Other Insurance ("Crowd Out Rule")

Note: **You may not be eligible for the MSI program if you have been covered by other health insurance in the last three (3) months unless one of the following occurs:**

- Loss or change of jobs,
- You moved into an area where employer sponsored coverage is not available,
- Your employer discontinued health benefits to all employees,
- Coverage was lost because the individual providing the coverage died, legally separated, or divorced,
- Health coverage was provided under a federal Consolidated Omnibus Budget Reconciliation Act (COBRA) policy, and the COBRA coverage ended.

F. Temporary Eligibility (TE)

Thirty days of temporary eligibility is granted only under special circumstances. Once granted, the application process continues to determine if the patient is eligible for the full twelve months of coverage and if appropriate, may include retroactivity of up to 3 months. If it is determined the patient does not qualify for the MSI program, eligibility will discontinue at the end of the 30 day eligibility period.

TE is granted in the following circumstances:

- An urgent medical condition exists that requires complex interventions, and has the potential for a poor outcome if there is a delay in treatment.
- A high likelihood that necessary services will be significantly delayed because of the provider's reluctance to evaluate/treat a patient without healthcare coverage.
- An MSI application is completed, and patient meets financial, identity, and Orange County and legal U.S. residency criteria.

In-patient: (Coordinated through UMD: (714) 634-5169)

Patients already hospitalized are only granted TE in the following circumstances:

- Hospital notifies UMD of the admission/diagnosis as outlined in the MSI/ Hospital contract.

AND

- Patient requires transfer to another facility for a higher level of care or a necessary procedure not provided at the current facility, or the patient is ready for discharge and requires complex out-patient management.

Note: **Exceptions to the above criteria must be approved by the MSI Program Administrator.**

Out-patient: (Coordinated through Patient/Provider Relations office: (714) 834-3557 option 5)

Patients must meet criteria as outlined under: "TE is granted in the following circumstances."

V. GENERAL BILLING INFORMATION

Advanced Medical Management (AMM) currently serves as the Fiscal Intermediary for the MSI program. The timeline for claims submission is 90 days from the date of service or from the date noted on the Notice of Action (NOA) letter—eligibility approval letter—whichever is later. The final date for claims receipt by the Fiscal Intermediary in the current fiscal year is November 30. The only exception to this rule applies to retro active enrollment. Physicians must use a CMS-1500 Form for claims submission. Electronic submissions are preferred. All billing must include the following information:

- Patient's name
- MSI member identification number or Social Security number
- Date of service
- Provider Tax Identification number

- Billed Charges
- HIPAA Compliant CPT and ICD-9 codes
- National Provider Identifier (NPI)
- Date of Birth

Submission of claims after close of contract period (exception policy)
There is only one exception to the billing deadline noted above: Patients who are initially denied MSI eligibility and subsequently granted eligibility through the SSA Appeal or Administrative Review process.

There can be a lengthy delay from the time the patient submits an appeal to the time SSA receives information to rescind the original denial of eligibility. As a result, the patient may receive notification of eligibility after the contract period is closed.

Providers who receive information that a patient has been granted eligibility (through the appeal or administrative process) for a closed contract period, should do the following:

- Ask the patient for a copy of their NOA (the approval letter from SSA that confirms eligibility for the date of service in question).
- Attach a copy of the patient's NOA to the claim, and submit the claim to the fiscal intermediary, AMM.

Important Note: **Claims submitted after the deadline due to pending MSI eligibility verification issues are rolled forward and considered for payment under the succeeding year's contract.**

A. Billing by Hospitals

Inpatient Utilization Management Department

The MSI Program's Utilization Management Department (UMD) must be notified of all MSI patient (eligible or pending) hospital admissions. To notify of an admission, call **(714) 634-5169.**

Note: **Failure to send concurrent review upon request or discharge information within 10 days to the Utilization Management Department will result in denial of non-reported hospital days regardless of eCEDA use or not.**

Hospitals must use the UB92 or UB04, Questions regarding Hospital Point Calculation may be directed to the Fiscal Intermediary, AMM. All hospitals are required to bill electronically.

Hospitals are paid a Periodic Interim Payment (PIP) each month calculated using historical data.

Claims are reviewed by the Fiscal Intermediary to determine patient eligibility, timeliness of submission, and if the medical care rendered falls within the MSI Scope of Service. If the claim meets the necessary criteria, an initial credit is given. Calculation of the initial credit is based upon 80% of the point values. Points are valued at the total paid in the previous year ($48.12 for FY 2006-2007).

A final determination of the amounts due to all hospital contractors, adjusted for PIP, are made by January 15 of the following year and communicated to all hospitals. The notice includes notification to any hospital that has received an over-payment, and a demand for immediate repayment due within ten (10) days. Final distribution of all amounts due to hospitals is made on or before January 31 for the prior contract year.

Hospital Billing Points

POINT TABLE

E.R. Outpatient Categories	Points
Minor w/o Ancillary—MD Only	1.00
Minor w/o Ancillary—Room Only	1.00
Minor w/o Ancillary—Room w/Professional Component	2.00
Minor w/ Ancillary—MD Only	3.25
Minor w/ Ancillary—Room Only	3.25
Minor w/ Ancillary—MD & Room	4.00
Minor w/ Ancillary—MD, Room & Professional Component	4.75
MD & Room Only—Physical Therapy	5.50
Ancillary Only—Level 1	2.50
Ancillary Only—Level 2	1.75
Major Ancillary	7.00
Major w/o Ancillary—MD Only	3.75
Major w/o Ancillary—Room Only	3.75
Major w/o Ancillary—MD & Room	7.50
Major w/ Ancillary—MD Only	10.75
Major w/ Ancillary—Room Only	10.75
Major w/ Ancillary—MD & Room Only	10.75
Surgical Procedure—Ancillary Only	1.75
Surgical Procedure w/o Ancillary—MD Only	3.75
Surgical Procedure w/o Ancillary—Room Only	3.75
Surgical Procedure w/o Ancillary—MD & Room	7.50
Surgical Procedure w/ Ancillary—MD Only	5.50
Surgical Procedure w/ Ancillary—Room Only	5.50
Surgical Procedure w/ Ancillary—MD & Room	9.25

Inpatient Points	Contracted Hospital	Receiving Hospital
Acute Days	15	21
Critical Days	40	40
Acute & Telemetry (step-down)	20	24
Nursing Care Day – Level Two	8	8
Nursing Care Day – Level One	6.5	6.5
Admin Days	6	6
High Tech Ancillary	10 x Conversion Factor	10 x Conversion Factor

High Tech Ancillary – For both inpatient and outpatient claims, a payment in addition to the points assigned above is calculated for services considered to be High Tech Ancillary. Some examples are:

High Tech Ancillary	Points
Hyperbaric Chamber	20
Lithotripsy (Water bath type) Inpatient	20
Lithotripsy (Water bath type) Outpatient	30
Electrodes – Each (Water bath type only)	5
MRI/Pet Scans – Inpatient	10
MRI/Pet Scans – Outpatient	15
Radiation Therapy (per diem)	5
Surgical Implants – Prosthetics	1 Point for every $200 on the invoice with no maximum (Invoice must accompany the claim).

Trauma Points	
Patient Expired in E.R.	32
Patient Expired in O.R.	149
Admitted	38

Upon mutual written agreement, contracted hospitals and Administrator may adjust the above categories and corresponding point values.

B. Billing the Patient

1. **Billing and Collection Practices**

Providers have the right to bill patients in the event the patient fails to complete the eligibility process, receive a non-insurance third party settlement,

or if the services provided are determined to fall outside the scope of the MSI program. However, providers may not perform unfair billing practices in which the patient is balance billed for services covered under the MSI Program.

Note: **• Beginning September 1, 2007, hospitals may charge a $25 co-pay for emergency room services. Co-payments are not deducted from the net hospital reimbursement. Also, Medical Home providers may charge a $5 co-pay under circumstances as stated above.**

2. **Deposits**

a. ***Emergency Services***

Deposits should not be required prior to providing treatment for persons needing emergency medical treatment as that term is defined in *Section 1317 of the Health and Safety Code,* i.e., "in danger of loss of life or serious injury or illness."

b. ***Medically Necessary Services***

Deposits may be requested, but hospitals may not deny medically necessary services (i.e., cannot be postponed without seriously affecting health) to potentially eligible or eligible persons who fail to pay the deposits. *Welfare and Institutions Code Sections 14134.1 and 16804.1.*

C. Billing by Physicians and Community Clinics

Physicians and community clinics are required to credential with the MSI program once every two years as a condition for reimbursement. To credential on-line, please go to *https://ochca.amm.cc/register.aspx.* September 1, 2008 was the most recent credentialing period for all physicians and clinics.

Claims submitted by physician or community clinic providers who are not credentialed are moved into a temporary suspended status. The Fiscal Intermediary will send the physician or clinic a notification that the claims are suspended with instructions to credential with the Program within **fourteen (14)** days from the date on the letter of notification. Physicians or clinics who do not credential within the 14-day time-frame, will not receive reimbursement.

Physicians and clinics must use the CMS-1500 and it must contain information mentioned in the General Billing Information Section.

Upon approval of MSI'S Utilization Management Department (UMD), Advanced Medical Management (AMM) shall reimburse certain physician groups specified by UMD and authorized in writing by the County, at rates negotiated by the County in the form of a Letter of Agreement (LOA). LOA's with MSI shall be limited to certain types of specialties and/or geographic areas for which physician services

are not otherwise available to MSI members. The rates negotiated shall constitute payment in full and are not subject to Final Settlement as defined for all other providers. The County will provide copies of all LOA's to AMM and UMD.

Note: • **All laboratory and diagnostic imaging services ordered by physicians are rendered through MSI contracted facilities. Physicians may however, provide these services in their private offices and bill the Fiscal Intermediary directly under certain circumstances such as patient transportation issues. However, it is preferred that the provider refer the patient to a contracted laboratory or imaging center as these facilities send the reports back to MSI in electronic form which attaches to the patient's continuity of care record. For further information on where to refer, please contact UMD.**

All MSI eligibles are required to have a Medical Home. Medical Homes may charge a $5 co-pay if a patient visits their unassigned Medical Home. The co-pay is not deducted from the physician's net reimbursement. The assigned Medical Home is available to providers on-line at *www.ocmsipov.com.* Patients may change their Medical Home once every 30 days by calling the Patient Education Department (PED) at (800) 417-4262, option 1, or sooner under special circumstances.

D. Billing for Pharmaceutical Services

The MSI program has a drug formulary. The formulary is available on-line at *www.ochealthinfo.com/medical/msi/providers/news.htm*.

In certain cases, the MSI program may cover a non-formulary drug where one of the following conditions is present: all formulary options have been ineffective, or another non-formulary drug is less expensive, or there is overwhelming clinical evidence that the patient will have an improved quality of life, or the diagnosis is within the scope of the MSI program and is consistent with the prescription.

The MSI Drug Authorization Request Form is required when a physician requests a non-formulary medication (See Appendix D).

AMM may reimburse outpatient pharmaceutical costs typically not claimed through MSI's Pharmacy Benefits Manager (PBM), including chemotherapy and other injectable drugs provided in Physician offices. Reimbursement of pharmaceutical costs by AMM shall not exceed what would otherwise be paid by MSI's PBM unless authorized in writing by MSI. MSI will provide AMM the reimbursement rates in effect with MSI's PBM and any exceptions. Other pharmaceutical costs or costs from other non-hospital outpatient providers may be paid by AMM upon written authorization by MSI. Claims will not be considered by AMM for payment unless the J-Code and the NDC # are provided on the claim.

RxAmerica Network pharmacies provide eligible pharmaceuticals. A list of participating pharmacies is available on-line at *http://www.ochealthinfo.com/medical/msi/providers/news.htm.*

E. Billing for Emergency Transportation

Emergency medical transportation to a contracted hospital, necessary to protect life, and/or prevent significant and permanent impairment in health status and/or function of eligible patients, is reimbursable through MSI. Non emergency medical transportation services are not eligible for reimbursement, with the exception of transfers qualifying as a Special Permit Medical Service, and ambulance services associated with the transfer of an MSI pending or eligible patient from UCI to a receiving hospital as defined in the Medical Services Initiative Agreement.

Ambulance companies must indicate diagnosis on the transportation claim.

Ambulance companies are reimbursed at 100% of prevailing Medi-Cal rates.

Note: **Paramedic services are not reimbursable through the MSI Program.**

Eligibility information is available from the patient, the MSI On-Line Eligibility Verification System, Fiscal Intermediary, or the MSI Patient/Provider Relations Office.

F. Billing for Durable Medical Equipment (DME)

Suppliers of Durable Medical Equipment must use the standard CMS 1500 form. All DME services must be prior-authorized by the MSI Program's UMD. They can be reached by calling (714) 634-5169.

Approved claims for medical supplies are reimbursed at 100% of prevailing Medicare for similar items. (See Appendix A.1 for Scope of Service criteria).

G. Billing for Home Health Services (HHS)

Providers of Home Health Services may bill the MSI program for reimbursement. All Home Health services must be prior authorized by the MSI Program's UMD. They can be reached by calling (714) 634-5169. Home Health Care Agencies must use the standard CMS 1500 form when submitting claims to the Fiscal Intermediary.

Approved HHS claims are reimbursed at 100% of prevailing Medicare rates for similar services. (See Appendix A.1 for Scope of Service criteria.)

VI. REVIEW COMMITTEE

Medical Review Committee (MRC)

The Medical Review Committee reviews provider and patient appeals to determine if services provided qualify as reimbursable medical services under the MSI Agreement. The Committee's decision is rendered within 30 days of the receipt of an appeal by the Fiscal Intermediary. The Medical Review Committees' decisions are final and binding.

The Committee consists of a physician chairperson appointed by the County, a physician member appointed by OCMA and a physician member appointed by the Hospital Association of Southern California. MRC also includes employed and contracted Registered Nurses from the County, UMD, the Case Management Unit, and the County's Medical Director. The MSI Administrator and Associate Administrator also serve on the MRC.

VII. APPEALS

Appeal of Denied Claims

Provider questions regarding eligible charges may be referred to the current Fiscal Intermediary, Advanced Medical Management at (800) 206-6591. Providers may appeal claims denied as outside the Scope of Service to the Medical Review Committee (MRC). Appeals must be submitted, in writing, within thirty (30) days of the notice of denial, to Advanced Medical Management, P.O. Box 30248, Long Beach, CA 90853.

Patients also receive a timely notice of every denial of provider payment with the reason for the denial, an explanation of the patient's appeal rights and an appeal form. Patient appeals must be submitted in writing, within 30 days of the Notice of Payment Denial to: Advanced Medical Management, P.O. Box 30248, Long Beach, CA 90853. Patients may be represented by an attorney or any other person of their choice.

The appeal must be accompanied by records, medical opinions, arguments or other pertinent information the patient or their authorized representative(s) believe would be relevant to establish the pertinent facts. The Medical Review Committee (MRC) considers this information in addition to the information contained in the claim file to reach a final decision. The patient is notified in writing of the Committee's decision.

VIII. TRANSFER POLICY

Hospitals and other providers are not paid for any medical services if the hospital transfers or accepts a patient transfer, **except** when said patient requires a "special permit medical service," which is not available at the transferring hospital, or when the receiving facility is a specialized receiving hospital as defined in the MSI Program Hospital Services Agreement.

Special permit medical services are defined for purposes of the MSI Agreement as follows:

- Burn Center
- Cardiovascular surgery service
- Radiation therapy services

- Trauma center
- Renal transplant center
- Acute psychiatric service
- Special rehabilitation service
- Authorized transport from acute care to a skilled nursing facility or a sub-acute hospital unit.

Note: **Special Permit Transfers are approved in writing by the MSI Administrator and/or Medical Director.**

All special permit services must be licensed in accordance with appropriate laws and must be a service provided by a contracted hospital.

Transfer other than for a "special permit medical service" may be recommended to the Administrator and/or Medical Director under the following circumstances:

A. In-County Transfers

1. Patient is an established MSI eligible at the time of transfer; and
2. Patient was hospitalized under emergency circumstances which precluded facility selection in advance; and
3. Patient has an existing relationship with a physician which the patient and the physician wish to maintain; and
4. Physician noted above does not have staff privileges at the hospital where the patient was admitted; and
    a. Patient's condition was stabilized prior to transfer; and
    b. Both the receiving hospital and the physician agree in advance to the transfer.

B. Out-of-County Transfers

1. Patient is an Orange County resident; and
2. Patient was hospitalized under emergency circumstances which precluded facility selection in advance; and
3. Patient may or may not be an established MSI eligible at the time of transfer; eligibility may be determined subsequent to the transfer; and
4. Patient's condition was stabilized prior to transfer; and
5. Both the receiving hospital and physician agree in advance to the transfer.

The receiving facility must notify the Fiscal Intermediary of the transfer via a letter. The letter must indicate the following:

1. Name and address of the patient
2. Reason for the transfer
3. Acceptance by the receiving facility and physician of the transferred patient (the physician's signature is desirable).

The Fiscal Intermediary notifies the Administrator and the Medical Director of the transfer. The Administrator or Medical Director notifies the Fiscal Intermediary in writing of the disposition of the transfer request.

APPENDIX A

SCOPE OF SERVICE

MSI is a medical safety-net program for adults. Services are considered for reimbursement if the medical service is required for:

- Primary care and disease prevention.
- Early intervention to stop or limit the spread of disease.
- Immediate treatment of life-threatening and emergent conditions.
- Treatment of acute exacerbation of chronic conditions that are potentially life or limb threatening.
- Observation/management of chronic conditions that are potentially life threatening.
- Treatment of conditions that would otherwise result in significant and permanent impairment in health status and/or function.

The scope of covered medical services may include but is not limited to the following:

- Acute hospital inpatient services, including physician, room and board, diagnostic and therapeutic ancillary services, therapy services, anesthesia services, pharmacy services, administrative days, nursing care days and other acute hospital inpatient services necessary to the care of the patient
- Home Health services
- Outpatient services, including physician, clinic services, hospital based surgical center services, emergency room services, diagnostic and therapeutic services, outpatient pharmacy services and physical and occupational therapy services
- Blood and blood derivatives
- Hemodialysis
- Emergency medical transportation
- Primary, preventive, and surgical Dental services
- Durable Medical Goods, prosthetics and medical supplies
- Acute psychiatric evaluation as required for triage
- Skilled nursing care
- Sub-acute care

APPENDIX A—*continued*

Exclusion and Limitations (Unless Otherwise Approved by Letter of Agreement):

1. All services for health conditions, which do not meet the purpose of the Program
2. Pregnancy related services including complications of pregnancy (exception: urine “dip stick” to test for pregnancy)
3. Extended or long-term care facility service
4. Eyeglasses for refraction and eye appliances, hearing aids
5. Routine injections of antigen to ameliorate allergic conditions
6. Medications not listed in drug formulary
7. Adult day care health services
8. Acupuncture/chiropractic services
9. Non-emergency medical transportation
10. Voluntary sterilization and birth control
11. Inpatient and outpatient mental health services
12. Inpatient and outpatient alcohol and drug rehabilitation
13. Diagnostic and therapeutic services for male and female fertility
14. Organ transplant (Refer to Medi-Cal)
15. Radial Keratotomy and other laser surgeries to correct refractive impairments
16. All diagnostic, therapeutic and rehabilitative procedures and services which are considered experimental or of unproven medical efficacy
17. Cosmetic procedures (exception: reconstructive surgery, post mastectomy)
18. Personal convenience items for inpatient stay
19. Ultrasound, massage and therapeutic thermal packs

APPENDIX A.1

MEDICAL SERVICES INITIATIVE
SCOPE OF SERVICE GUIDELINES

INTRODUCTION

Pre-certification is required for all specialty referrals. Please contact the MSI Program's **Utilization Management Department at (714) 634-5169** for pre-certifications.

Claims with ***no tracking number*** will be handled in the following manner:

1. Hospital days
   a. Will be denied. This will include professional services performed for the same episode of care.
   b. Pre-certification will generally be done on a concurrent basis.
   c. Mental health and drug and alcohol diagnoses will be pended for review.
2. Specialty physician services
   a. Will be processed at the MSI base rate if the services are within the scope of the program. If a Letter of Agreement exists between MSI and the provider, the base rate will supersede the LOA rate.
   b. Pre-certification will be done on a prospective basis.
   c. Sub-authorizations will be allowed. For example, a referral to an orthopedist automatically allows for pre-certification of radiological services, or a referral to a cardiologist allows for electrocardiograms, etc.
3. SNF days
   a. Will be denied.
   b. Pre-certification will be done on a prospective basis.
4. Sleep studies
   a. Will be denied.
   b. Pre-certification will be done on a prospective basis.
   5. Ancillary services such as lab and diagnostic do not require a tracking number unless the service includes higher cost items such as nuclear testing, CT, MRI, EEG, cardiac testing, invasive imaging, or Holter monitoring.
   a. Will be denied.
   b. Pre-certification will generally be done on a concurrent basis.

APPENDIX A.1—*continued*

6. Emergency Department services
   a. Will be covered. No pre-certification required.
7. General practitioner services
   a. Will be covered. No pre-certification required.

The Following Diagnoses (ICD-9) are Not Within Scope of the MSI Program:

BegDiag	EndDiag	ICD Category	Notes	Contract Category Letter
290.0	319.9	Mental Disorders		L
367.0	367.9	Disorder of refraction and accomodation		G
606.0	606.9	Infertility Male		H
628.0	628.9	Infertility Female		H
630.0	677.0	Compliations Of Pregnancy		C
700.0	700.0	Corns and Callouses	If performed by a Podiatrist	G
703.0	703.9	Disease of nail	If performed by a Podiatrist	G
727.1	727.1	Bunion	If performed by a Podiatrist	G
V20.	V39.	Well child, Pregnancy, newborn		C
V45.5	V45.59	IUD		H
V53.1	V53.1	Spectacles and Contact lenses		F
V53.4	V53.4	Orthodontic Devices		G
V59.	V59.9	Donors		B
V60.	V61.9	Homeless – Mental Social		L
V65.	V65.9	Other person seeking consultations		L
V79.	V79.9	Special screening for mental disorders and developmental handicaps		L

Other Services to Note Under the MSI Program Scope:

DURABLE MEDICAL GOODS
(Mandatory prior authorization)

Contact the MSI program's **Utilization Management Department at (714) 634-5169.**

All Durable Medical Goods are paid at 100% Medicare rates. Rental payments are made up to (and do not exceed) the purchase price of the equipment item.

Covered:

1. Items such as wheelchairs and walkers when clinically indicated
2. Supplies for ostomy and wound care
3. Braces:
    a. Off-the-shelf
    b. Custom orthopedic braces including cast braces
4. CPAP (Continuous Positive Airway Pressure):

ONLY when symptomatology and documented clinical evidence substantiates need. Documented clinical evidence must include:

- >15 apnea episodes/hour
- < 84% 0_2 saturation level and/or cardiac arrhythmias

5. C.P.M. (Continuous Passive Motion) Equipment:

For two weeks post discharge after joint surgery, could be longer with documentation to substantiate need.

6. Electronic Bone Stimulation:

    Approval based upon:

    a. Current x-rays (and x-rays taken at the time of the original injury)
    b. Six-months nonunion
    c. History and physical

7. O_2 Therapy: **(Per Medi-Cal/Medicare Guidelines)**
    a. Payment per month based on rate of 2L/min continuous

b. Portable O_2 (E tank) for exercise activity limited to two tanks per month

c. Liquid O_2 concentrator, or Large O_2 tanks (H tank)

8. Prosthetic Devices:

a. Appliances necessary for the restoration of function

b. When prescribed by a licensed physician

c. When provided by a prosthetist, orthotist or a licensed physician

Note: **Reimbursement (post-amputation) is only available for one permanent prosthetic device. It is advisable to delay fitting (of the prosthesis) until maximum shrinkage occurs. MSI does not pay for temporary devices.**

Excluded:

- T.E.N.S. Unit
- Disposable diapers
- Disposable underpads
- Food supplements

HOME HEALTH

The following guidelines for service are the maximum allowable for 30 days based upon diagnosis:

Skilled Nursing Care

Six (6) visits maximum

Exception: IV antibiotic therapy

Physical and/or Occupational Therapy

a. Must be homebound: with adequate progress documented

b. Total of eight (8) visits

Speech Therapy

a. Must be homebound: with adequate progress documented

b. Total of eight (8) visits

Excluded:

Services provided by Home Health Aides or Social Workers.

OUT OF COUNTY SERVICES

The MSI program does not cover services provided outside of Orange County. In rare instances, Out-of-County services may be approved based upon the following criteria:

The Medical Review Committee or the Administrator must confirm all of the following:

1. The procedure is medically necessary and is the most effective method of treatment, and
2. Is within the MSI Scope of Service, and
3. Is not available in Orange County, and
4. Is not experimental/investigative in nature, and
5. The outside county facility may be contracted for trauma-based services only.

PHARMACY

Covered:

The MSI drug formulary is available on the MSI website:

www.ochealthinfo.com/medical/msi/providers/news.htm

PHYSICAL THERAPY

Covered:

Exercise modalities only when service is billed through a contracted hospital, a Home Health Care Agency, or the treating orthopedist's office. When billed through the physician's office, the physician's tax I.D. number must be listed.

Excluded:

- Hot packs
- Massage
- Ultrasound

PSYCHIATRIC AND DETOXIFICATION SERVICES

Covered:

1. Medically necessary treatment of acute symptoms of alcohol or drug ingestion and/or withdrawal
2. Only acute initial psychiatric evaluation as required for Emergency Room triage, i.e., to determine if there is an underlying psychiatric problem that caused or is contributing to the presenting medical anomaly

Excluded:

Mental health, social work and alcohol related services. These services are provided through the Orange County Health Care Agency's Behavioral Health Program.

The Following Procedure Codes (CPT) are Not Within Scope of the MSI Program:

Beg Cpt	End Cpt	Code Category	Notes	Contract Category Letter
11719	11765	Trim Nails	Except If Billed With Diabetic Diagnosis	G
11950	11954	Cosmetic Procdedure		J
11975	11977	Steriliz W/Birth Con		H
15775	15776	Cosmetic Procedure		J
15780	15793	Cosmetic Procedure		J
15819	15839	Cosmetic Procedure		J
15876	15879	Cosmetic Procedure		J
17110	17111	Plantar Wart		G
30150	30160	Cosmetic Procedure		J
32851	32856	Transplant-Lung		B
33930	33945	Transplant-Heart		B
45560	45560	Elective A&P Repair		
47133	47147	Transplant-Liver		B
48550	48556	Transplant Pancreas		B
49525	49525	Hernia Repair		
50300	50380	Transplant-Renal		B
55250	55250	Vasectomy		H

APPENDIX A.1—*continued*

Beg Cpt	End Cpt	Code Category	Notes	Contract Category Letter
58300	58301	Steriliz W/Birth Con		H
58600	58615	Steriliz W/Birth Con		H
58970	58976	In Vitro Fert		H
59000	59899	Pregnancy		C
65710	65755	Transplant-Cornea		B
65771	65771	Radial Keratomy		F
69090	69090	Cosmetic Procedure		J
90801	90899	Mental Health	Covered Under BHS	L
92551	92597	Audiometry Screening		F
95115	95199	Immunotherapy		I
97010	97010	Phy Therapy Hot Pcks		K
97035	97035	Phy Thrpy Ultrasound		K
97124	97124	Phy Thrpy Massage		K
97810	97814	Acupuncture		G
98940	98943	Chiropractic		G
99324	99337	Physian Svcs Ltc		D
99509	99510	Home Health		L
A0021	A0210	Emerg Med Transport		N
A0424	A0424	Ambulance		N
A4261	A4261	Steriliz W/Birth Con		H
A4266	A4269	Steriliz W/Birth Con		H
G0155	G0156	Home Health		L
J7300	J7306	Steriliz W/Birth Con		H
S9434	S9434	Food Supplements		
V2020	V2799	Vision Services		G
V5000	V5999	Hearing Aids		F
S5100	S5101	Adult Day Care		
		HIV Medications	Covered Under HIV Planning And Coordination Unit (HIVPAC)	

APPENDIX B

MSI FRAUD AND RECOVERY PROGRAM

The MSI program has limited resources. In order to maximize reimbursement rates, providers of care need to collect from any liable third party payer for medical services provided to an MSI eligible. Third party payers may include Medi-Cal, Workers Compensation, liability lawsuits, and private insurance.

The ADMINISTRATOR may authorize INTERMEDIARY to subcontract with a Third-Party Recovery Group (Recovery Group) for the purpose of actively pursuing reimbursement of claims paid for MSI eligibles later determined to be eligible for Medi-Cal or other PRIMARY OTHER INSURANCE.

MSI does not coordinate benefits. Therefore, MSI may not be secondary to any payer and is strictly a program of last resort. Should a provider receive a payment from another payer in addition to payment from MSI, the provider is obligated to reimburse MSI the amount MSI paid to the provider. If the patient becomes retroactively eligible under another payer, such as Medi-Cal or Medicare, MSI or MSI's recovery agent may request reimbursement for any dates of services that fall under the other payer's eligibility period.

Every month, MSI performs an eligibility check of its full population against the State's Medi-Cal program. Therefore, if points are issued to a hospital when MSI finds there to be other coverage for the date of service in question such as Medi-Cal, the hospital has the responsibility to reimburse MSI the dollar value of the points to MSI's recovery agent. However, should the hospital discover other coverage through its own efforts, hospital must notify MSI's fiscal intermediary so it can retract any point values issued for dates of services in question.

In cases where an MSI eligible receives a liability settlement, the providers may pursue collection of 100% of their allowed charges. The Fiscal Intermediary or the Program's designated recovery agent and the MSI Fraud and Recovery Department must be notified of any third party settlement.

If any Provider receives reimbursement from a third-party settlement for services reimbursed, said provider must reimburse INTERMEDIARY an amount equal to the MSI payment or the third-party settlement, whichever is less. Third-party settlement payments may be directed by any Provider to be paid directly to COUNTY if the date(s) of service related to the claim are such that the Provider has already written off the patient account.

INTERMEDIARY and All Providers must cooperate with the Recovery Group in recovering these costs. Except as provided for above, monies recovered due to the efforts of the Recovery Group must be reimbursed to the Recovery Group. The Recovery Group, after deduction of appropriate administrative fees, must remit the balance to INTERMEDIARY for

deposit as follows: ten percent (10%) into the HCA Recovery Account and the remainder into the Physician Recovery Account or Hospital Recovery Account, as appropriate.

Note: **Providers must furnish Program's designated recovery agent such records and documentation as recovery agent may reasonably require to maintain centralized data collection and referral services in support of third-party revenue recovery activities.**

Providers who have concerns about possible patient fraud may call and leave information on the

MSI program's confidential Fraud line at:

(714) 834-3557, option 5.

APPENDIX C

PATIENT REFERRALS TO THE MSI PROGRAM BY OUTPATIENT PROVIDERS

The purpose of this procedure is to give providers of service information on how to screen and refer patients to the MSI program for eligibility determination. Patients, who are not currently eligible for the MSI or Medi-Cal programs and have no other resource for medical care, may be referred for MSI eligibility screening.

Appointments to apply for the MSI program are made by calling the MSI CMAT at an MSI contracted hospital or qualified community clinic **(See Appendix E):**

- Where the provider is on staff, or
- The patient is to receive treatment, or
- The contracted facility is closest to the patient's home

I. Outpatient Provider Role:

1. Contacts the MSI CMAT at a contracted hospital or qualified community clinic to arrange an appointment for the patient to apply for MSI benefits, or
2. Instructs the patient to contact the MSI CMAT
3. Obtains status of patient's MSI eligibility by accessing the MSI Provider On-line Verification System

Note: **Providers of service should take steps to obtain eligibility information to ensure timely billing.**

II. Patient Role:

1. Keeps appointment with the hospital or community clinic CMAT and brings all necessary paperwork to complete application process.
2. Notifies all providers of service of the final disposition of the MSI application.

III. Hospital/Community Clinic Staff Role:

1. Gives an appointment to the patient for MSI eligibility screening and informs patient of necessary paperwork needed at time of appointment
2. Takes the MSI application
3. Assigns the patient to a Medical Home that is most appropriate for the patient based on patient preference, cultural competency, and distance from the patient's primary residence.

4. Forwards the completed application to the MSI Unit of the Social Services Agency

IV. MSI Unit of the Social Services Agency Staff Role:

1. Evaluates the MSI application for completed information
2. Verifies information on the MSI application
3. Determines eligibility status

V. Fiscal Intermediary Staff Role:

1. Processes claims from providers of service for MSI eligibles

VI. Netchemistry

1. Provides online eligibility status reports to hospitals and qualified community clinics of all eligibility actions taken.

APPENDIX D

1. DRUG FORMULARY FOR MSI (General Information)

The MSI program currently utilizes a closed, restrictive formulary that is commensurate with the Medi-Cal and CalOptima formularies in format, albeit more restrictive. The Formulary is available on-line at *www.ochealthinfo.com/medical/msi/providers/news.htm.*

a. **Covered**

Medications listed in the MSI drug formulary.

b. **Amounts of Medications Dispensed**

Limited to a maximum of eight prescriptions per month. Some supplies, such as Needles, Syringes, Lancets, Diabetic Test Strips, and Monitors, are excluded from this limit. Generic medications must be used whenever possible and appropriate (no dispense as written [DAW]). All medications have dollar and quantity limits.

c. **Ancillary Pharmacy Items**

- Home I.V. therapy: Standard equipment
- Customary ostomy supplies
- Diabetic materials: Insulin syringes and testing materials

Note: **Beginning September 1, 2007, the MSI program will only cover the True Track glucose meter and TrueTrack test strips. These products are manufactured by Home Diagnostics, Inc. Any questions regarding these products may be directed to:**

Patients:..... (800) 803-6025 ..... (Truetrack Helpline)

Pharmacists: ..... (310) 721-7631 ..... (Julie Hyer)

Physicians: ..... (800) 342-7226 ext. 7621... (Cathy Herman)

2. NON-FORMULARY DRUGS

Non-formulary drugs are covered on an exception to the rule basis. The MSI Program in those instances may cover a non-formulary drug when one of the following conditions is present:

All formulary options have been ineffective, or another non-formulary drug is less expensive, or there is overwhelming clinical evidence that the patient will have an improved quality of life, or the diagnosis is within the scope of the MSI program and is consistent with the prescription.

If a physician wants to request the MSI program pay for a non-formulary drug, and one of the above mentioned conditions is present, he or she must complete a Drug Authorization Request form (see below). The form is also available by calling the RxAmerica Customer Support Desk at (800) 511-7453 or online on MSI's Provider website: *www.ochealthinfo.com/medical/msi/providers/news.htm.* The MSI program's Medical Review Committee determines the coverage of all non-formulary drug requests. Their decisions are final and binding. The committee meets monthly (you may call MSI's main number at (714) 834-6248 to confirm the next meeting). In order for a request to be placed on the agenda for a particular month, the respective form must be completed and received no later than the Thursday preceding the committee meeting.

The procedure for submission of the MSI Drug Authorization Request form is as follows:

a. Prescribing physician confers with the pharmacist to determine if a formulary drug may be substituted. If not, physician completes physician section of the form. Physician may also complete the pharmacy section if the information is available. If the information is not available, the form should be faxed to the pharmacy for completion.

b. Information on the form must include the patient's name, social security number, diagnosis and any other information regarding the patient's condition that may assist the Medical Review Committee in rendering a decision. Information may include lab results and the failure of other therapeutic agents. **Writing must be legible.**

c. The completed form is sent (via facsimile) to the MSI Fiscal Intermediary at **(562) 766-2006.**

Note: **The MSI program currently contracts with RxAmerica for pharmacy management services. Prescriptions must be filled at RxAmerica participating pharmacies. A list of these pharmacies is available by calling the RxAmerica Customer Support Desk at (800) 511-7453 or by checking the MSI Provider website at: *www.ochealthinfo.com/medical/msi/providers/news.htm.***

If a pharmacist has trouble accessing the RxAmerica system they may call (888) 862-3378 for assistance.

APPENDIX E

MSI CONTRACTED HOSPITALS

Anaheim General Hospital
3350 W. Ball Road
Anaheim, CA 92804
(714) 220-4514

Anaheim Memorial Medical Center
1111 W. La Palma Avenue
Anaheim, CA 92801
(714) 999-6161

Chapman Medical Center
2601 E. Chapman Avenue
Orange, CA 92869
(714) 633-0011 ext. 1119

Coastal Communities Hospital
2701 South Bristol Street
Santa Ana, CA 92704
(714) 754-5454

Fountain Valley Regional Hospital and Medical Center
17100 Euclid
Fountain Valley, CA 92708
(714) 966-3316

Garden Grove Hospital and Medical Center
12601 Garden Grove Boulevard
Garden Grove, CA 92843
(714) 741-2713

Hoag Memorial Hospital Presbyterian
1 Hoag Drive, P.O. Box 6100
Newport Beach, CA 92708
(949) 764-8271

Huntington Beach Hospital and Medical Center
17772 Beach Boulevard
Huntington Beach, CA 92647
(714) 843-5000

Irvine Medical Center
16200 Sand Canyon Avenue
Irvine, CA 92618
(949) 753-2173

Kaiser Permanente
441 N. Lakeview Avenue
Anaheim, CA 92807
(714) 279-4072

La Palma Inter-Community Hospital
7901 Walker Street
La Palma, CA 90623
(714) 670-6091

Long Beach Memorial Medical Center
2801 Atlantic Avenue
Long Beach, CA 90806
(562) 933-2000 (Trauma only)

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720
(562) 799-3116

Mission Hospital Regional Medical Center
27700 Medical Center Road
Mission Viejo, CA 92691
(949) 365-2116

Orange Coast Memorial Medical Center
9920 Talbert Avenue
Fountain Valley, CA 92708
(714) 378-7588

Placentia Linda Hospital
1301 Rose Drive
Placentia, CA 92870
(714) 524-4257

MSI CONTRACTED HOSPITALS

Saddleback Memorial Medical Center
24451 Health Center Drive
Laguna Hills, CA 92653
(949) 452-3177

Saddleback Memorial Medical Center at San Clemente Campus
654 Camino De Los Mares
San Clemente, CA 92673
(949) 496-1122 ext. 4960

South Coast Medical Center
31872 Coast Highway
Laguna Beach, CA 96251-6775
(949) 499-7166

St. Joseph Hospital—Orange
1100 West Stewart Drive
Orange, CA 92868
(714) 771-8107

St. Jude Medical Center
101 East Valencia Mesa Drive
Fullerton, CA 92835
(714) 992-3000 ext. 3341

University of California—UCI Medical Center 101
The City Drive, Rte. #62
Orange, CA 92868
(714) 456-6324—Customer Service
(714) 456-5703—E. R.
(714) 456-6401—Outpatient Registration

West Anaheim Medical Center
3033 W. Orange Avenue
Anaheim, CA 92804
(714) 827-3000 ext. 7346

Western Medical Center/Anaheim
1025 S. Anaheim Boulevard
Anaheim, CA 92805
(714) 502-2668

Western Medical Center/Santa Ana
1001 North Tustin Avenue
Santa Ana, CA 92705
(714) 953-3409

APPENDIX E—*continued*

MSI PARTICIPATING COMMUNITY CLINICS

Camino Health Center 30300 Camino Capistrano, San Juan Capistrano, CA 92675	(949) 240-2272
Clinica Medica de Ella 2223 W. 1st Street, Santa Ana, CA 92703	(714) 973-9218
El Modena Health Clinic 4010 E. Chapman Avenue, Orange, CA 92869	(714) 532-6222
Gary Center 341 Hillcrest, La Habra, CA 90631 (Dental Services Only)	(562) 691-3263
Hurtt Family Medical Clinic One Hope Drive, Tustin, CA 92782	(714) 247-0300
* Huntington Beach Community Clinic 8041 Newman Avenue, Huntington Beach, CA 92647	(714) 847-4222
* La Amistad Family Health Center 353 South Main, Orange, CA 92868 (Dental)	(714) 771-8006 (714) 771-8005
Laguna Beach Community Clinic 362 Third Street, Laguna Beach, CA 92651	(949) 494-0761
* Nhan Hoa Comprehensive Health Care Center 14221 Euclid Street, Suite H-I, Garden Grove CA 92643	(714) 539-9999
* St. Jude Neighborhood Health Center 731 S. Highland Avenue, Fullerton, CA 92832 (Dental)	(714) 446-5100 (714) 446-5245

APPENDIX E—*continued*

MSI PARTICIPATING COMMUNITY CLINICS

* Share Our Selves (SOS) 1550 Superior Avenue, Costa Mesa, CA 92627	(949) 650-0640
Sierra Health Center 501 South Brookhurst Road, Fullerton, CA 92833	(714) 870-0717
UCI Family Health Center—Anaheim 300 West Carl Karcher Way, Anaheim, CA 92805	(714) 456-7002
* UCI Family Health Center—Santa Ana 800 North Main Street, Santa Ana, CA 92701	(714) 456-7002
* VNCOC Asian Health Center 5015 K-L West Edinger Avenue, Santa Ana, CA 92704	(714) 418-2040

* Dental services available

For a full list of Medical Home providers, please check our provider website at:

www.ochealthinfo.com/medical/msi/providers/news.htm.

APPENDIX F

MSI AND MEDI-CAL COMPARISON

The Medical Services Initiative Program is an Orange County program that provides necessary medical services for persons between the ages of 21 and 64 who are not eligible for Medi-Cal and who have no other resource for medical care.

Medi-Cal is a State run program that provides Temporary Assistance to Needy Families (TANF), and medical services for persons who qualify for long term disability. The Medi-Cal Program provides a wider scope of services not limited to providers within Orange County.

The following services are covered by Medi-Cal but **excluded** from **MSI:**

1. Pregnancy-related services, including complications of pregnancy
2. Extended or long-term care facility services
3. Adult day-care health services
4. Acupuncture, chiropractic, optometry
5. Hearing aids, eye glasses for refraction and eye appliances
6. Orthotic devices and other similar devices
7. Non-emergency medical transportation services, including ambulance services in non-emergency situations
8. Intermediate cares services

Appropriately billing Medi-Cal for reimbursement for medical services conserves the fixed MSI funds. All MSI providers benefit from these savings as any dollars left over at the end of the year get distributed to qualifying providers. All reasonable efforts should be made to refer an applicant to apply for Medi-Cal when an applicant is identified as potentially disabled.

Medi-Cal disability applications forwarded to the Disability Determination Services Division (DDSD) are processed more expeditiously if copies of medical records (particularly test results) are attached to the application. Records such as x-rays, laboratory results, copies of physical exams, operative reports, etc., speed up the Department of Alcohol and Drug Programs (DADP) decision.

If a patient in an acute care facility is to be discharged to a long-term care facility, every attempt should be made to complete a Medi-Cal application.

Occasionally, MSI and Medi-Cal applications are taken simultaneously. Persons initially admitted as MSI patients may be Medi-Cal eligible if their illness or injury results in long-term disability. In these cases, the SSA Eligibility Technician should be asked to take a Medi-Cal application based upon long-term disability. To qualify for this category, the State must determine that the patient will be disabled for a period of at least twelve (12) months. Certification of Medi-Cal eligibility takes approximately four (4) to six (6) months and sometimes longer.

There are some disabling conditions that allow for **presumptive** Medi-Cal eligibility. An application can be processed immediately at the local level if the patient's SSA Eligibility Technician is provided with medical documentation of one of the following:

(see next page)

APPENDIX F—*continued*

No.	IMPAIRMENT CATEGORIES
1	Amputation of two limbs
2	Amputation of a leg at the hip
3	Allegation of total deafness
4	Allegation of total blindness
5	Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a longstanding condition—excludes recent accident and recent surgery
6	Allegation of a stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm
7	Allegations of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms
8	Allegation of diabetes with amputation of a foot
9	Allegation of Down syndrome
10	Allegation of severe mental deficiency made by another individual filing on behalf of a client who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities. ***Note:* "Mental deficiency" means mental retardation. This Presumptive Disability (PD) category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine daily activities (e.g., fastening a seat belt) grossly exceeds age-appropriate dependence as a result of mental retardation.**
11	A child is age 6 months or younger and the birth certificate or other evidence (e.g., the hospital admission summary) shows a weight below 1200 grams (2 pounds 10 ounces) at birth.
12	Human immunodeficiency virus (HIV) infection. (See below for details on granting PD for HIV infection.)

APPENDIX F—*continued*

<table>
<tr><th>No.</th><th>IMPAIRMENT CATEGORIES</th></tr>
<tr><td>13</td><td>A child is age 6 months or younger and available evidence (e.g., the hospital admission summary) shows a gestational age at birth on the table below with the corresponding birth-weight indicated:

Gestational Age (in weeks) — Weight at Birth

37 – 40 — Less than 2000 grams (4 pounds, 6 ounces)
36 — 1875 grams or less (4 pounds, 2 ounces)
35 — 1700 grams or less (3 pounds, 12 ounces)
34 — 1500 grams or less (3 pounds, 5 ounces)
33 — 1325 grams or less (2 pounds, 15 ounces)</td></tr>
<tr><td>14</td><td>A physician or knowledgeable hospice official confirms an individual is receiving hospice services because of terminal cancer.</td></tr>
<tr><td>15</td><td>Allegation of inability to ambulate without the use of a walker or bilateral hand held assistive devices more than two weeks following a spinal cord injury with confirmation of such status from an appropriate medical professional.</td></tr>
</table>

APPENDIX G

NOTICE OF ACTION (NOA) LETTER

The Notice of Action (NOA) document is used to inform the applicant/recipient of the eligibility status of their MSI application. The applicant/recipient is responsible to inform all providers of medical services of their eligibility status. Providers may also obtain information on eligibility status from the:

MSI Provider On-line Verification System. To access this system, go to

www.ocmsipov.com.

MSI Program
Patient/Provider Relations/Fraud and Recovery
P.O. Box 335
Santa Ana, CA 92702

Providers Only (714) 834-3557
Patients Only (714) 834-5211
or
(866) 613-5178

SSA Eligibility Information Line (866) 979-6772

The following are samples of NOA letters:

- Approval of Temporary 30-day eligibility
  (See Appendix G–1)

The following chart lists all of the currently used notices by code. Code numbers appear on the lower left-hand corner of the Notice of Action.

(See next page)

Appendix G—*continued*

APPROVAL NOTICES OF ACTION TABLE	
First Character	
1	Regular Application
2	Fair Hearing Resolution
3	Administrative Review Resolution
4	Amnesty Application
Second Character	
A	Regular Applicant
B	Applicant becomes 65 years old during 6 months
C	Applicant's alien expiration date during 6 months
DENIAL AND OTHER NOTICES	
Code	**Description**
11	Deny—Failure to cooperate and/or provide information. Requires entry of reason on second screen.
12	Deny—Timely Application. Application was received after the 90-day deadline or after end of contract deadline.
13	Deny—Resident. Not an Orange County Resident.
14	Deny—Alien. Alien without legal resident status in U.S.
15	Deny—Excess resources. Total property reserves exceed allowable limit. NOA will display property as listed on screen. (No longer a criteria under MSI)
16	Deny—Age. Under 21 or over 65 years of age. Referred for Medi-Cal application.
17	Deny—Medi-Cal. Person is currently Medi-Cal eligible.
18	Deny—Institution. Person is resident of institution.
19	Excess income.
20	Excess Resources and Poverty Level. Resources and income both exceed program limits.
21	Deny—identification. Failure to provide required proof of identification.
22	Deny—Residency. Failure to provide required proof of residency.
31	Pend Dual Medi-Cal (not DAPD) person identified as possible Medi-Cal link, MSI pended for Medi-Cal determination.
32/34	No application processed. Person identified is currently certified. Encounter falls within current certification period. Reapply at end of certification period.
33	Previously denied eligibility. Reapplication for a month in which eligibility has already been determined.

DENIAL AND OTHER NOTICES

Code	Description
35	Pend Dual Medi-Cal Person identified as possible link to Medi-Cal based on disability. MSI may be approved while awaiting Medi-Cal determination.
SE1	Suspension for identification
SE2	Suspension for residency
SE3	Suspension for Income/Assets
DE1	Discontinuance for identification
DE2	Discontinuance for residency
DE3	Discontinuance for Income/Assets
DE10	Discontinuance for Medi-Cal eligibility
ADMINISTRATIVE DISCONTINUANCE NOA CODES	
AE1	Identification
AE2	Residency
AE3	Income/Assets
AE4	Linkage

APPENDIX G-1 (SAMPLE NOA)

COUNTY OF ORANGE
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION
MEDICAL SERVICES INITIATIVE

MSI 239 I
Notice Date
Case Name
Member ID
Number

MSI Eligibility Information Line
Telephone (866) 979-6772
Address P.O. Box 70017
Anaheim, CA 92825-0017

NẾU QUÝ VỊ CÓ THẮC MẮC VỀ QUYỀN LỢI CỦA
QUÝ VỊ XIN GỌI THẲNG "MSI" ĐIỆN THOẠI SỐ

SÍ TIENE PREGUNTAS DE ESTA NOTICIAS
DE ELEGIBILIDAD DEL PROGRAM DE "MSI"
LLAME EL TELEFONO "MSI INFORMATION LINE"

Name
Street
City, State, Zip code

Dear Mr/Mrs/Ms

Your Medical Services Initiative application of (App Date) has been approved effective (Elig Start) through (Elig End) granting Temporary Eligibility for 30 days only. Your application for MSI benefits is also under evaluation to determine if you qualify to receive MSI eligibility for a 12-month period. Continue to cooperate with your Eligibility Technician during this evaluation process. If you qualify, you will receive a separate "Notice of Action" letter giving you your effective dates for your 12-month eligibility period.

This action is required by the following laws and/or regulations.

MSI Manual Sections:
200-5 Eligibility Determination
MSI Eligibility Procedures Manual:
200.1-6 MSI Application and Case Processing

Addendum II – Temporary Eligibility 1T1

IMPORTANT NOTICE
ON THE BACK OF THIS FORM.
(Provider Note) Send Claims to:
Advanced Medical Management (AMM)
MSI Claims
P.O. Box 30248
Long Beach, CA 90853

PATIENT EDUCATORS are available for any **GENERAL** questions about the MSI program; you may contact the Patient Education Department at (800) 417-4262, select option 1.

REGISTERED NURSES are available for your MEDICAL concerns, 24 hours a day, 7 days a week. Call the Nurseline at (877) 402-7111.

PRESCRIPTIONS for MSI Eligible may be filled at a **RX AMERICA** Participating Pharmacies, Group code – OCMSI, BIN # 610743, Plan code - CRK

COUNTY OF ORANGE HEALTH CARE AGENCY
MSI-MEDICAL SERVICES INITIATIVE

P.O. Box 355
Santa Ana, CA 92702-0355
Phone: (714) 834-6248
Fax: (714) 834-6292

Name:
Member ID:
RxBin: 610473
Medical Home (PCP): Refer to www.ocmsipov.com

On-Line Patient Eligibility Verification:
www.ocmsipov.com

Member Copays:
• Visit to Non-Medical Home: $5
• Non Emergent ER Visit: $25

COUNTY OF ORANGE HEALTH CARE AGENCY
MSI - MEDICAL SERVICES INITIATIVE

24/7 Nurse Line: (877) 402-7111
Patient Relations: (714) 834-5211 or (866) 613-5178
Patient Education Dept: (800) 417-4262 select option 1

PROVIDER USE ONLY
Send Claims to:
Advanced Medical Management (AMM)
MSI Claims
P.O. Box 30248
Long Beach, CA 90853
Claims: (800) 206-6591 or (562) 766-2000
Provider Relations: (714) 834-3557
Utilization Mgmt. Dept: (714) 634-5169

APPENDIX H

Article III. ELIGIBILITY APPEAL RIGHTS

You have the right to request a hearing. Your request for a hearing must be in writing. Your request for a hearing must be within 30 days of the date of this notice.

If you request a hearing, you will be given notice of the time, date, and place. When you receive your Notice of Hearing, you must confirm your intent to appear at the hearing or your appeal will be automatically denied. Instructions for confirmation appear on the Notice of Hearing. You have the right to examine all documents and records to be used at the hearing. You may represent yourself or you may be represented by an attorney or any other person (a friend, relative, or other spokes-person) of your choice. You or your representative may bring witnesses, establish pertinent facts, make arguments, cross examine witnesses, and refute testimony or evidence. If you want to ask for free legal advice, contact the nearest Legal Aid Society office.

Following the hearing, the hearing officer will issue a written decision. The decision becomes final when adopted by the Administrator of the Medical Services Initiative Program.

You may request a hearing by completing the request on this form and either leaving the entire form at the reception desk or mailing it to Orange County Social Services Agency, Appeal Unit, P.O. Box 22001, Santa Ana, California 92702-2001, within 30 days of the date of this notice.

(DO NOT DETACH)

I request a hearing on the action taken regarding Medical Services Initiative assistance. I dis-agree with this action because

_____

_____

_____

_____

I will be represented by an authorized representative ☐ Yes ☐ No

Name of representative:

_____

_____
Signature

_____

_____
Address

_____
City Zip

_____
Telephone

_____
Date

APPENDIX I

PROCEDURES FOR REFERRAL TO ORANGE COUNTY PSYCHIATRIC CENTRALIZED ASSESSMENT TEAM (CAT) AND EVALUATION AND TREATMENT SERVICES (ETS)

Psychiatric services are not covered under the MSI program. The following information is for reference only.

Centralized Assessment Team (CAT)

This is a program of the Orange County Health Care Agency Behavioral Health Services Division, and is funded through the Mental Health Services Act (MHSA).

This team provides evaluation for involuntary psychiatric hospitalization (5150) and is available for any adult who is at psychiatric risk, has a psychiatric emergency, or needs psychiatric hospitalization. They respond anywhere in Orange County, and are available 24 hours a day, seven days a week. They are not able to provide assessments for patients in acute care or skilled nursing facilities.

To contact the team call toll-free: (866) 830-6011 or (714) 517-6353.

Evaluation Treatment Services (ETS)

This service is in place to facilitate the evaluation/transfer of medically stable indigent persons (to a County psychiatric Unit) who meet admission criteria as outlined under W&I Code 5150.

Admission Criteria:

- Any indigent person between the ages of 18 and 65 who by reason of mental disorder is in imminent danger of harming himself/herself or others or is gravely disabled and may require in-patient psychiatric evaluation and treatment.

- Any indigent person 65 years of age and older who by reason of mental disorder is in imminent danger of harming himself/herself or others or is gravely disabled and may require in-patient psychiatric evaluation and treatment. Persons in this age range must first be evaluated in a medical emergency department to rule out concomitant or contributing medical problems.

- Any person suffering from the effects of toxic substances (e.g., drugs, alcohol, poisons) is not appropriate for admission until medically stable.

- Any person in custody (jail) is not appropriate for referral or admission.

Appendix I—*continued*

Referral procedure (from HCA staff):

- All Agency referrals must be preceded by a phone call. No persons will be admitted without phone approval.

- ETS staff will inquire about the person's behavior, medical status (if known) and the circumstances under which the person is being referred.

Referral procedure (from hospital, clinic or physician office):

- **Hospital:** Hospital staff who receive persons in the ER who may meet admission criteria to a County psychiatric facility, should call County ETS at (714) 834-6900.

- **Clinic/physician office:** Clinic/physician office staff who determine an individual meets admission criteria, should call the closest Adult Outpatient Mental Health Clinic; these facilities are listed in the MSI Patient Handbook. The Handbook may be viewed at: *www.ochealthinfo.com/medical/msi/resources.htm* or you may request a copy from MSI Program Support at (714) 834-6248.

Note: **If the referral does not meet admission criteria, County ETS staff will give the person who requests the referral, the most appropriate alternative resource.**

APPENDIX J

NOTICE OF PAYMENT DENIAL
(Front of Form)
Medical Services Initiative
Advanced Medical Management
P.O. Box 30248 Long Beach, CA. 90853
(800) 206-6591

NOTICE OF PAYMENT DENIAL
THIS IS NOT A BILL

Date of letter
Patient name
Address
City, State Zip

MSI Client:
Case #:
Date of Service:
Amount of Claim: $
Provider:
Date of Denial:

Service: Hospital Services

Reason for Denial: Services provided are not within the scope of MSI program. (Medical Services Agreement, Exhibit E and Provider Manual Criteria for Interpretation of the Scope of Service **)

The scope of the MSI Program is "medically necessary care to protect life, prevent significant disability, or to prevent serious deterioration of health". The claim for the medical care rendered on the above date of service has been denied because it does not meet this test of medical necessity.

You may appeal the denial within 30 days of the date in the heading of this letter. To appeal the denial you must complete the form on the back of this letter, which includes a statement of your appeal rights, or submit a written statement with the same information specified on the form. The completed form or written statement must be sent within the 30-day time limit to:

Advanced Medical Management
P.O. Box 30248 Long Beach, CA. 90853
Attn: Patient Appeals

This is not a request for payment.
Please Note: Claims information is not available over the telephone.

** Copies available for review or purchase.
Information about the MSI program's covered/non-covered benefits is in the MSI Patient Handbook and Provider Manual. These documents are available on the following MSI websites: www.ochealthinfo.com/medical/msi (Patient Handbook) and www.ochealthinfo.com/medical/msi/providers/news.htm (Provider Manual). You may also request a copy of these documents by calling the MSI Program Support line at (714) 834-6248.

APPENDIX K

NOTICE OF PAYMENT DENIAL
(Back of Form)

DENIED PROVIDER CLAIM APPEAL RIGHTS

You have the right to appeal this denial of payment. To appeal, you must complete this form and attach a copy of your medical record(s) for the specific date(s) of service noted on the front of this form which you or your authorized representative(s) believe is relevant. Medical records are available from your provider of service (physician and/or medical records department of respective hospital). Examples of medical records may include copies of physician progress notes, MRI, ultrasound, X-ray, and laboratory results.

Mail completed form and medical records within thirty (30) days of the date of this Notice of Denial to: Advanced Medical Management, P.O. Box 30248, Long Beach, CA 90853. In lieu of a written appeal, you may request an oral appeal (which may be conducted over the phone). The completed form and pertinent medical records are still required and must be submitted prior to oral appeal. If you have questions regarding the appeal process, call (800) 206-6591.

You may represent yourself or an attorney or any other person of your choice may represent you. If you wish to ask for free legal assistance, contact your nearest Legal Aid Society Office, telephone number is (800) 834-5001.

After your appeal has been evaluated, the MSI program's Medical Review Committee (MRC), a panel of three physicians, will make a final determination based on submitted documentation. You will receive a document entitled, "Notice of Review Decision" informing you of the MRC's determination. All decisions of the MRC are final and binding.

If you are submitting an appeal, please return this form for proper handling.

Date: _____

Name: _____

Current Address: _____ Date of Birth: _____

_____ S.S.#: _____

Telephone Number: _____ Best time to call: _____

Provider Name: _____ Date of Service: _____

What is the reason for your appeal? _____

_____

_____

APPENDIX L

MSI DENTAL FEE MATRIX

The Dental Fee Matrix is available on the MSI provider website at: *www.ochealthinfo.com/medical/msi/providers/news.htm.* Effective December 2008, MSI created a panel of private dentists to assist community clinic dentists with the increasing demand for dental services. An updated list of dental providers is posted on the MSI provider website above.

1. Fees payable to providers by MSI for covered services shall be the LESSER of:
    a. Provider's billed amount
    b. The maximum allowance set forth in the posted schedule.
2. A $1,000 benefit cap will be set per patient per eligible year.