PROVIDER MANUAL

2015 - 2016

MEDICAL SAFETY NET PROGRAM

P.O. BOX 355
SANTA ANA, CA 92702

www.ochealthinfo.com

TABLE OF CONTENTS

APPENDICES

I. INTRODUCTION

The Medical Safety Net (MSN) Program was established in January 2014 by the County of Orange Health Care Agency to meet Orange County's obligations under California Welfare and Institutions Code Section 17000.

The MSN Program delivers care through a partnership between the County of Orange and the private medical community. This program provides services that are medically necessary to protect life, prevent significant disability, or prevent serious deterioration of health.

All MSN enrollees will choose a Community Clinic during the MSN application process to coordinate all necessary follow-up care. The enrollee's assigned clinic is generally the only provider (other than the hospital emergency room) who does not need authorization to provide care.

MSN Enrollees may change their assigned Community Clinics once during their eligibility period.

Services provided by a clinic where the member is not assigned, will not be covered unless prior authorized by the MSN Program.

MSN Important Phone Numbers

MEDICAL SAFETY NET (MSN) Program Patient Eligibility On-line Verification
www.ocmsipov.com

Medical Safety Net (MSN) Program
Patient/Provider Relations/Fraud and Recovery
P. O. Box 355
Santa Ana, CA 92702

Providers Only (714) 834-3557
Patients Only (714) 834-5211

Fiscal Intermediary/Claims Processing/Recovery Agent Services

Advanced Medical Management, Inc.
Attention: MSN Program
P. O. Box 3689
Long Beach, CA 90853

Phone: (800) 206-6591

MSN Program Care Coordination Unit (CCU)/Inpatient Authorization/Outpatient Authorization

Main Line: (714) 834-3557

Authorization Fax: (714) 834-6292

Pharmacy Benefits Manager

MedImpact Healthcare Systems, Inc.
10680 Treena Street, Stop 5
San Diego, CA 92131

Phone: (800) 788-2949

II. MSN PROGRAM FACILITIES

A. Hospitals

Hospitals participating in the MSN Program have the ability to choose the level of service they will provide to MSN enrollees. Available service levels are:

- Network Hospital
- Contracting ED Hospital
- Non-Contract Hospital

1. Network Hospitals

Under the MSN Network Hospital Agreement (available at www.ochealthinfo.com), Network Hospitals are required to perform the following actions:

a. Comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).

b. Designate one or more staff members to serve as Certified MSN Application Technicians (CMAT) and screen potential MSN patients for Medi-Cal, commercial insurance, and MSN program.

c. Coordinate with CCU to assist in the evaluation of the enrollee's medical stability and need for continued hospitalization, discharge planning; transfer to lower level of care (including Recuperative Care); and, arrangement of necessary follow-up care as dictated by the enrollee's clinical condition.

d. Accept the transfer of MSN enrollees initially receiving emergency and stabilization services at contracting ED Hospitals or Non-Contract Hospitals.

e. Provide any service, as medically appropriate, to MSN enrollees within the scope of the hospital's licensure.

2. Contracting ED Hospitals

Under the MSN Program Emergency Department and Post-Stabilization Services Agreement (available at www.ochealthinfo.com), Contracted ED Hospitals are required to perform the following actions:

a. Comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).

b. Designate one or more staff members to serve as Certified MSN Application Technicians (CMAT) and screen potential MSN patients for Medi-Cal, commercial insurance, and MSN program.

c. Coordinate with CCU to assist in the evaluation of the enrollee's medical stability for transfer to an MSN Network Hospital, a lower level of care (including recuperative care), or discharge, as appropriate.

d. Coordinate with the CCU to authorize an inpatient stay at the contracting ED hospital, if a transfer or discharge cannot be arranged.

e. Provide any service, as medically appropriate, to MSN enrollees within the scope of the hospital's licensure.

3. Non-Contract Hospitals

All Non-Contract Hospitals, including those hospitals located outside of Orange County, must complete the MSN electronic registration process (available at ***https://ochca.amm.cc/register.aspx***). Registration as a participating provider is mandatory to receive any reimbursement from the MSN Program.

Non-Contract Hospitals are required to perform the following actions:

a. Comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).

b. Coordinate with the MSN Care Coordination Unit (CCU) within 72 hours of any MSN enrollee admission by contacting (714) 834-3557, option5 l or via facsimile, as applicable.

1. Coordinate with CCU to assist in the evaluation of the enrollee's medical stability for transfer to an MSN Network Hospital, a lower level of care (including recuperative care), or discharge, as appropriate.

2. Coordinate with the CCU to authorize an inpatient stay at the non-contract hospital if a transfer or discharge cannot be arranged.

3. Non-contract hospitals located outside of Orange County should notify CCU within seventy-two (72) hours of initial encounter. Some services may require authorization for reimbursement. Please see Appendix J for more information.

c. Provide any service, as medically appropriate, to MSN enrollees within the scope of the hospital's licensure.

B. Community Clinics

Under the MSN Program (available at www.ochealthinfo.com), Community Clinics are required to perform the following actions:

1. Complete the MSN electronic registration process (available at ***https://ochca.amm.cc/register.aspx***). Community Clinics must register all physicians, physician assistants, and nurse practitioners providing care to MSN enrollees.

2. Designate one or more staff members to serve as Certified MSN Application Technicians (CMAT) and screen potential MSN patients for Medi-Cal, commercial insurance, and MSN program.

3. Provide necessary follow-up care to MSN Enrollees, as medically appropriate. Follow-up care may include, but is not limited to, the following:

    a. Necessary treatment after a hospital or emergency department visit

    b. Treatment to ameliorate or control a chronic medical condition such as asthma, congestive heart failure, hypertension, or diabetes

    c. Diagnostic and therapeutic treatments within scope of the MSN program

    d. Urgent or emergent dental procedures, as necessary

    e. Specialty physician services, as medically appropriate, provided within the Community Clinic setting. Specialty services provided within the Community Clinic do not require authorization.

If the Community Clinic cannot provide the needed/desired specialty within the clinic setting, the Clinic should request a referral from the MSN Care Coordination Unit by completing and faxing the Authorization Referral Request form to (714) 834-6292.

C. Physicians and Other Providers

Under the MSN Program Physicians and Other registered Providers are required to perform the following actions:

1. Complete the MSN electronic registration process available at ***https://ochca.amm.cc/register.aspx***

2. Where applicable, coordinate and make arrangements for the medical needs and care of MSN Enrollees.

D. MinuteClinics

MinuteClinics are available for after-hours care (evenings and weekends) when a member has an urgent or immediate medical need and the assigned clinic is unavailable or the member feels he/she cannot wait for an appointment. Board certified practitioners are available every day. No appointments are necessary

III. PATIENT ELIGIBILITY

A. Requirements of Eligibility

The Medical Safety Net Program (MSN) program covers necessary medical care to Orange County's residents who meet the following requirements:

- Urgent or emergent medical condition that, if left untreated, would pose a serious detriment to the individual's health status
- Between the ages of 19 and 64
- Lawful resident of Orange County
- Citizen or lawful resident of the United States
  - Permanent Residents Under Color of Law (PRUCOL)
  - Deferred Action Status Alien
  - Those with confirmed refugee status including VAWA (Violence Against Women Act)
- Have no medical coverage
- Ineligible for Medi-Cal
- Income over 138% and equal to or less than 200% of Federal Poverty Level (FPL). Individuals with suspected incomes less than 138% of FPL should immediately be screened for MAGI Medi-Cal or Traditional Medi-Cal eligibility.
- Compliance with Income Limitations
- Compliance with Property Limitations

MFBU Size	1	2	3	4	5
Property Limits	$ 2,000	$ 3,000	$ 3,150	$ 3,300	$ 3,450

If the resources exceed the limits for the family size, the applicant is not eligible for MSN assistance, but may spend down assets in the encounter month in order to become eligible.

B. Determination of Eligibility

Eligibility for the MSN program is determined by the MSN Eligibility Unit. Proof of Orange County residency, citizenship or resident status, 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 MSN Application Technician (CMAT), the forms are forwarded to the MSN Eligibility Unit for review and processing. Information on the application is verified through various automated databases and provided documentation.

IV. MSN PROGRAM COVERED and EXCLUDED SERVICES

A. Covered Services

The Medical Safety Net (MSN) Program is a safety-net program for adults meeting the stated eligibility criteria. A medical service is considered for reimbursement under the Medical Safety Net Program, if such medical service is required for:

1. Immediate treatment of life or limb threatening and emergent conditions.
2. Treatment of acute exacerbation of chronic conditions that are potentially life threatening.
3. Limited monitoring of chronic conditions that are potentially life threatening.
4. Medical conditions that, if left untreated, would result in permanent and significant impairment in health status.

The scope of covered medical services may include the following:

- Acute hospital inpatient* services which include:
  - Physician or hospitalist services
  - Room and board
  - Diagnostic and therapeutic ancillary services
  - Therapy services
  - Anesthesia services
  - Pharmacy services
  - Hospital inpatient services necessary to the care of the patient
- Home Health Services**
- Outpatient services which, when authorized and deemed medically necessary, include:
  - Physician services
  - Clinic services
  - Surgical center services**
  - Emergency room services
  - Diagnostic and therapeutic services
  - Outpatient pharmacy services
  - Physical and occupational therapy services**
- Blood and blood derivatives
- Acute outpatient dialysis**
- Emergency medical transportation
- Emergency dental services
- Durable medical equipment**
- Skilled Nursing Care**

B. Excluded Services and Limitations

The following services do not meet the criteria of the MSN Program and are not reimbursable:

- All services for health conditions that are not medically necessary to protect life and/or prevent permanent and/or significant impairment of function.
- All allergy testing, desensitization, and related diet programs.
- Pregnancy related services including complications of pregnancy.
- Extended or long-term care facility services.
- Hormone therapy including Hormone Replacement Therapy
- Routine physical examinations.
- Routine dental prophylaxis and radiological studies, orthodontia, and fixed prostheses.
- Routine eye examinations, eyeglasses for refraction, and eye appliances, hearing aids.
- Routine injections of antigen to ameliorate allergic conditions.
- Medications within therapeutic classifications that fall outside the scope of the MSN Program.
- Medications that are not FDA approved.
- Medications not listed on the Medical Safety Net (MSN) Program formulary.
- All OTC (Over-the-Counter) Medications
- Adult day care health services.
- Acupuncture services.
- Chiropractic services.
- Podiatry services (except in cases of acute trauma or infection).
- Non-emergency medical transportation.
- Voluntary sterilization, birth control, or other family planning services.
- Inpatient and outpatient mental health services.
- Inpatient and outpatient substance abuse services.
- Organ transplants.
- Radial Keratotomy, LASIK, and other laser surgeries to correct refractive impairments.
- All cosmetic procedures.
- Personal convenience items for inpatient stay.
- All diagnostic, therapeutic, and rehabilitative procedures and services which are considered experimental or are of unproven medical efficacy.
- Ultrasound, massage, and therapeutic thermal packs.

V. MSN PROGRAM CO-PAYMENTS and COLLECTION EXCEPTIONS

It is the responsibility of MSN Providers to collect applicable co-payments for services provided to MSN Enrollees. The MSN Fiscal Intermediary will deduct the applicable co-payment from claims submitted by MSN Providers. Providers may keep all co-payments collected.

MSN Program Co-Payments are as follows:

Medical Service	**Co-Payment**
Emergency Room Visit	$300
Emergency Medical Transport	$300
Inpatient Hospital per Admission	$300
Outpatient Hospital Visit	$20
Follow-Up Care Visits (Clinic or Physician)	$60
Specialist Visit (Physician)	$70
Emergent or Urgent Dental Visit	$60
Laboratory Test	$45
X-rays and diagnostic imaging	$65
Advanced Imaging (PET/CT/MRI)	$75
Durable Medical Equipment	$90
Home Health Services	$45
Skilled Nursing Facility per Admission	$150
Urgent Care	$75
Minute Clinic Visit	$20

MSN Co-Payment Collection Exceptions

A. ED Hospital, Patient Transfer, Ambulance Services

1. Emergency Department Visits – The required co-payment for an Emergency Department Visit shall be waived if the MSN Enrollee is admitted to any inpatient setting, including recuperative care, immediately from the emergency department.

2. Inpatient Hospital Service Transfers – If an MSN Enrollee is transferred from one inpatient facility to another, only the initial admitting facility will collect the co-payment.

3. Ambulance Services – Co-payments shall be waived for medical transportation requested by a participating hospital or the MSN Care Coordination Unit for the transfer of a patient.

B. Physician and Clinic Visits

1. Emergency Department (ED) Physicians – ED Physicians shall not collect a co-payment for services provided in the emergency department. Co-payments will not be deducted from any reimbursement due to ED physicians for care provided to MSN enrollees.

2. No Additional Co-Payment for Laboratory Testing – For participating clinics and physicians, if blood or a specimen is collected during the same visit on the same day, only the co-payment for the office visit should be collected.

3. No Additional Co-Payment for Diagnostic Imaging – For participating clinics and physicians, if an X-ray or diagnostic image is taken during the same visit on the same day, only the co-payment for the office visit should be collected.

4. Surgical Center Co-Payment Waive – Any co-payment for the facility should be waived if there is a corresponding professional co-payment from the MSN enrollee at the time of service.

5. Only One Co-Payment per Day – Regardless of the number of services or visit provided in a single day at any single facility, only one co-payment per day may be collected.

VI. CARE COORDINATION UNIT

The MSN Care Coordination Unit (CCU) will assist hospitals with concurrent review, discharge planning, and post-discharge ancillary and specialty referrals for necessary follow-up care. Specifically, the MSN CCU can assist with authorizing and issuing a tracking number for the following:

- Authorization and arrangement for hospital inpatient services for MSN enrollees
- Transfers from Non-Contract, and Contracted ED Hospitals to MSN Network Hospitals
- Authorization and arrangement of skilled nursing facility (SNF) services
- Authorization and arrangement for home health services
- Authorization and arrangement for durable medical equipment (DME)
- Authorization and arrangement for specialty physician services for transition to outpatient settings

Urgent requests for referrals will be completed no later than seventy-two (72) hours or three (3) business days, whichever is later. Determination of the level of urgency is at the MSN CCU's discretion and will be based on submitted documentation, nationally recognized care guidelines, and the MSN Scope of Benefit.

Routine, non-urgent requests for referrals will be completed no later than fourteen (14) business days. Determination of the level of urgency is at the MSN CCU's discretion and will be based on submitted documentation, nationally recognized care guidelines, and the MSN Scope of Benefit.

Authorizations for hospital inpatient services, discharge planning, outpatient services, speciality services or follow-up care should be submitted to the CCU via facsimile to (714) 834-6292.

Authorizations for outpatient services, specialty services, or follow-up care should be made by completing the MSN CCU's Authorization Referral Request form and faxing it to (714) 834-6292.

VII. BILLING INFORMATION

Advanced Medical Management (AMM) currently serves as the Fiscal Intermediary for the MSN 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.

Claims may be submitted by mail or electronically.

Mail claims to:

Advanced Medical Management, Inc.
Attention: MSN Program
P. O. Box 3689
Long Beach, CA 90853

Electronic claims submission:

Claims Clearinghouse	Payer Identification Code
Office Ally	AMM13
Capario	MSN01
Emdeon	60521

All billing must include the following information:

- Patient's name
- MSN Member Identification Number or Social Security Number
- Date of Birth
- MSN Authorization Number, when applicable
- Date of service
- Provider Tax Identification number
- Billed Charges
- HIPAA Compliant CPT and ICD-9 codes
- Individual National Provider Identifier (NPI) (if applicable)
- Organizational National Provider Identifier (NPI) (if applicable)

A. Hospital Billing

Network and Contracted ED Hospitals must bill the MSN Program electronically.

Non-Contract hospitals may choose to bill electronically. If billing by paper, Non-Contract Hospitals must use the UB92 or UB04 claim form.

Implantable devices will be reimbursed as stated below and in accordance with the MSN Hospital Agreements. Documentation of the devices cost (invoice) must accompany the claim to be eligible for reimbursement.

Hospitals are reimbursed for services at a designated "interim rate" based on 2010 CalOptima rates. Network and Contracted ED Hospitals will receive a "Final Settlement" up to the maximum CalOptima rate specified in the tables below.

For Dates of Service on or after July 1, 2014, reimbursement, by hospital type, is as follows:

Network Hospital Reimbursement Rates
Inpatient Rate: 100% of hospital's certified CalOptima rate (per diem or APR-DRG.
Outpatient/ED Services Rate: 100% of CalOptima Fee-For-Service rates by CPT code.
Implantable Devices: 100% of invoiced cost if hospital is reimbursed at a per diem rate. If the hospital is reimbursed based on APR-DRG, then the cost of the implant is included in the calculation.

Contracted ED Hospital Reimbursement Rates
Inpatient Rate: 75 % of the Network Hospital's standard CalOptima per diem rate
Outpatient/ED Services Interim Rate: 75% of CalOptima Fee-For-Service rates by CPT code.
Implantable Devices: 100% of invoiced cost if hospital is reimbursed at a per diem rate. If the hospital is reimbursed based on APR-DRG, then the cost of the implant is included in the calculation.

B. Billing by Physicians and Clinics

Participating physicians and clinics must complete the MSN Registration process before reimbursement can occur.

Physicians and clinics may provide laboratory and imaging services within their own offices as appropriate. Laboratory testing and plain X-rays do not require prior authorization.

Physicians and clinics must use the CMS-1500 containing the required information mentioned above.

Physician Reimbursement Rates
Reimbursement: 100% of CalOptima Fee-For-Service rates by CPT code.

Community Clinic Reimbursement Rates

Reimbursement: 100% of CalOptima Fee-For-Service rates by CPT code.

C. Emergency Transportation Billing

Emergency medical transportation, including paramedic services, to the nearest hospital, necessary to protect life, and/or prevent significant and permanent impairment in health status and/or function of eligible patients, is reimbursable through MSN. Ambulance companies must indicate the diagnosis using standard ICD-9 codes on the transportation claim.

Emergency transportation does not require prior authorization. Ambulance companies are reimbursed at 100% of prevailing Medi-Cal rates.

D. Durable Medical Equipment (DME) Billing

DME suppliers must complete the MSN registration process to qualify for reimbursement. Providers must use the standard CMS 1500 form when claiming for reimbursement.

All DME services require prior authorization by the MSN Care Coordination Unit. Services provided before the MSN enrollee's application data may be subject to retrospective review.

Approved claims are reimbursed at 100% of Medi-Cal rates by CPT, as applicable. CPT codes without a specified Medi-Cal rate will be reimbursed at 100% of National Medicare rates. CPT codes without a Medi-Cal or Medicare rate may not be reimbursed.

E. Home Health Services (HHS) Billing

HHS suppliers must complete the MSN registration process to qualify for reimbursement. Providers must use the standard CMS 1500 form when claiming for reimbursement.

All HHS services require prior authorization by the MSN Coordination Unit. Services provided before the MSN enrollee's application data may be subject to retrospective review.

Approved claims are reimbursed at 100% of Medi-Cal rates by CPT, as applicable. CPT codes without a specified Medi-Cal rate will be reimbursed at 100% of National Medicare rates. CPT codes without a Medi-Cal or Medicare rate may not be reimbursed.

All pharmaceuticals related to home health services will be paid at the brand and generic rates detailed in the current MSN Pharmacy Benefits Manager agreement or one hundred percent (100%) of the prevailing Medicare rate whichever is lower.

F. Billing for Pharmaceuticals

The MSN program has a drug formulary. The formulary is available online at www.ochealthinfo.com.

In certain cases, the MSN 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 MSN program and is consistent with the prescription.

MSN co-payment rules will apply.

The MSN Drug Authorization Request Form is required when a physician requests non-formulary medications, and/or formulary medications that are over quantity limits or maximum cost or have specific time restrictions (e.g., psychotropic medications). The form should be faxed to the MSN Provider Relations Office at (714) 834-6292 for consideration.

The MSN Fiscal Intermediary may reimburse certain pharmaceuticals including chemotherapy agents and other injectable drugs provided in physician or clinic offices. Claims for injectables should be submitted with the applicable J-Code and NDC number for reimbursement. Pharmaceutical claims submitted without this information will be rejected as incomplete.

Pharmaceuticals will be paid at the brand and generic rates detailed in the existing MSN Pharmacy Benefits Manager agreement or one hundred percent (100%) of the prevailing Medicare rate whichever is lower.

G. MSN Recovery Program

MSN providers need to collect payment from any liable third party payer for medical services to an MSN eligible. Third party payers may include Medi-Cal, liability lawsuits, and private insurance. The Fiscal Intermediary acts as the recovery agent to pursue reimbursement of claims paid for MSN eligibles later determined to be eligible for Medi-Cal or other insurance/coverage.

MSN does not coordinate benefits. Therefore, MSN 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 MSN, the provider is obligated to reimburse MSN the amount MSN paid to the provider. If the patient becomes retroactively eligible under another payer, such as Medi-Cal, MSN or MSN's recovery agent may request reimbursement for any dates of service that fall under the other payer's eligibility period.

Every month, MSN performs an eligibility check of its current population against the State's Medi-Cal program. Therefore, if payment was issued to an MSN provider when MSN finds there to be other coverage for the date of service in question, the MSN provider has the responsibility to reimburse MSN the amount

MSN paid for the service. For example, hospitals will reimburse the MSN program based on their rate (i.e., full-service, emergency and stabilization or non-contracted). If an MSN provider discovers other coverage through its own efforts, the provider must notify MSN's Fiscal Intermediary which will coordinate reimbursement.

In cases where an MSN eligible receives a liability settlement, MSN providers may pursue collection of 100% of their allowable charges. The MSN Fiscal Intermediary 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 the Fiscal Intermediary an amount equal to the MSN payment or the third-party settlement, whichever is less. All providers must cooperate with the Fiscal Intermediary in recovering these costs. Providers must furnish Program's designated recovery agent such records and documentation as reasonably required in support of third-party revenue recovery activities.

The MSN Program, through the Fiscal Intermediary, reserves the right to withhold or reduce any future payments due to MSN providers who fail to cooperate in the recovery process, in order to effect the recovery of identified funds.

APPENDIX A – PROVIDER CLAIMS APPEALS

Providers have thirty (30) calendar days from the mailing date of the EOB to appeal any service or payment denial. Appeals must be submitted in writing using the designated appeals form included with the "Explanation of Benefits" (EOB) from the MSN Fiscal Intermediary and must be accompanied by the corresponding medical records.

All appeals submitted should include any additional information supporting the request to overturn the service or payment denial.

Appeals for service or payment denials will be considered timely when:

- Delivered personally, within thirty (30) calendar days of the mailing date of the corresponding EOB.
- Sent by first-class mail, expedited delivery, or by courier and received within thirty (30) calendar days of the corresponding EOB.

The MSN Fiscal Intermediary will not provide time extensions for appeals for any reason including:

- Sending the appeal form without the corresponding medical records and/or supporting documentation.
- Sending medical records and/or supporting documentation without the appeal form.
- Not knowing the appeal date because Provider cannot find or did not receive the EOB.

The appeal decision is final. Appeal decisions cannot be appealed again and, if submitted, will not be considered.

APPENDIX B – MSN PROGRAM SCOPE and BENEFIT LIMITATIONS

1. ACL RECONSTRUCTION: Only with documented instability of 6 months or more in essential activities of daily living and gross multi-ligament disruption.

2. All allergy testing, desensitization and related diet programs are excluded.

3. All routine audiometry tests for screening or to determine need for hearing aids are excluded along with hearing aids.

4. Carpel tunnel surgery excluded.

5. Cataracts covered when corrected vision in better eye is less than 20/70, night and close vision grossly impaired and/or there is associated or impending glaucoma present.

6. DENTAL SERVICES: Only extractions covered when indicated for pain, abscess, caries or impaction. Treatment for TMJ, periodontal disease, and cosmetic procedures excluded.

7. DERMATOLOGY: All warts, benign skin conditions, acne, and psoriasis excluded.

8. DIABETES: Diagnostic testing, home testing supplies, annual physical exam, laser surgery for retinopathy are covered. Eyeglasses are NOT covered.

9. DME: Covered items include: wheelchairs, walkers, ostomy, and wound care supplies, off the shelf orthopedic braces, CPM machine, electronic bone stimulator (with documented non-union); and food supplements when the sole source of nutrition.

   Excluded DME items include: TENS unit, disposable diapers, and underpads.

10. GYNECOLOGY: Covers D&C, excision of lesions or neoplasms, hysterectomy. Excluded are pregnancy and related conditions, tubal ligations, elective A&P repairs, hormone replacement therapy.

11. HEMORRHOIDECTOMY: Only when conservative management fails.

12. HERNIA: Strangulated or incarcerated only.

13. HOME HEALTH: 8 visits for PT/OT/ST must be homebound, with progress documented. Services of Social Workers excluded.

14. JOINT REPLACEMENT: Only as the result of acute trauma, infection, or avascular necrosis.

15. MENTAL HEALTH: Coverage limited to acute psychiatric evaluation as required for ER Triage. IP and OP Mental Health, Drug Abuse and Alcohol Services are excluded.

16. NASAL SUBMUCOUS RESECTION is excluded.

APPENDIX B – MSN PROGRAM SCOPE and BENEFIT LIMITATIONS (continued)

17. OBSTRUCTIVE SLEEP APNEA: Polysomnography, CPAP/BIPAP machines are covered only with a confirmed diagnosis of moderate/severe cardiopulmonary disease.

18. OPHTHALMOLOGY SERVICES: Limited to evaluations, treatment of diseases or injuries to the eye, lens implant following cataract surgery, laser surgery for diabetic retinopathy, annual diabetic exam. Excluded are ocular prosthesis, eyeglasses, routine refractions and radial keratotomy and any form of transplant (i.e., corneal).

19. PHYSICAL THERAPY: Exercise modalities only.

20. PLASTIC AND RECONSTRUCTIVE SERVICES: Limited to cancer-related mastectomies.

21. PSYCHIATRIC AND DETOXIFICATION SERVICES: Limited to treatment of acute symptoms of alcohol or drug ingestion and/or withdrawal and acute initial psychiatric evaluation in an Emergency Department.

22. SURGERY OF SPINE AND SPINAL CORD: Covered for Emergency conditions resulting from trauma, cauda equina syndrome, cervical spine disease with long tract signs, and severe back pain with evidence of spinal mass, arthritic defect, or infection, or radiculopathy with evidence of neurological progression.

23. SURGICAL INTERVENTION FOR EPILEPSY: Excluded.

24. TONSILLECTOMY: Must demonstrate three (3) or more pharyngeal strep infections in a twelve (12) month period, peri-tonsillar abscess, or suspected malignancy.

APPENDIX C – MSN PROGRAM EXCLUSIONS by DIAGNOSIS (ICD-9) CODE

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

BegDiag	EndDiag	ICD Category
290.0	319.0	Mental Disorders
367.0	368.74	Disorder of refraction and accommodation
606.0	606.9	Infertility Male
628.0	628.9	Infertility Female
630.0	677.0	Complications of Pregnancy
700.0	700.0	Corns and Callouses
703.0	703.9	Disease of nail
727.1	727.1	Bunion
977.0	977.9	Substance Abuse
V20.	V39.	Well child, Pregnancy, newborn
V42.0	V42.9	Organ or Tissue Transplant
V45.5	V45.59	IUD
V53.1	V53.1	Spectacles and Contact lenses
V53.4	V53.4	Orthodontic Devices
V59.	V59.9	Donors
V60.	V61.9	Homeless – Mental Social
V65.	V65.9	Other person seeking consultations
V70.0	V70.9	Routine Physical Exams
V72.0	V72.31	Routine Physical Exams
V72.42	V72.42	Pregnancy
V79.	V79.9	Special screening for mental disorders and developmental handicaps

APPENDIX D – MSN PROGRAM EXCLUSIONS by PROCEDURE (CPT) CODES

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

Beg Cpt	End Cpt	Code Category
10021	V9999	All Podiatry Services
11950	11954	Cosmetic Procedure
11975	11977	Sterilization w/Birth Control
15775	15776	Cosmetic Procedure
15780	15793	Cosmetic Procedure
15819	15839	Cosmetic Procedure
15876	15879	Cosmetic Procedure
17110	17111	Plantar Wart
30150	30160	Cosmetic Procedure
32851	32856	Transplant-Lung
33930	33945	Transplant-Heart
45560	45560	Elective A&P Repair
47133	47147	Transplant-Live
48550	48556	Transplant Pancreas
49525	49525	Hernia Repair
50300	50380	Transplant-Renal
55250	55250	Vasectomy
58300	58301	Sterilization w/Birth Control
58600	58615	Sterilization w/Birth Control
58970	58976	In-Vitro Fertilization
59000	59899	Pregnancy
65710	65755	Transplant-Cornea
65771	65771	Radial Keratotomy
69090	69090	Cosmetic Procedure
90000	99999	All Chiropractic Services
90785	90785	Mental Health
90791	90792	Mental Health
90832	90899	Mental Health
92551	92597	Audiometry Screening

APPENDIX D – MSN PROGRAM EXCLUSIONS by PROCEDURE (CPT) CODES (continued)

Beg Cpt	End Cpt	Code Category
95115	95199	Immunotherapy
97010	97010	Physical Therapy Hot Packs
97035	97035	Physical Therapy Ultrasound
97124	97124	Physical Therapy Massage
97810	97814	Acupuncture
98940	98943	All Chiropractic
99324	99337	Physician Service Long Term Care
99381	99429	Routine Physical Exam
99408	99409	Substance Abuse
99509	99510	Home Health
A0080	A0210	Non-Emergency Transport
A4261	A4261	Sterilization w/Birth Control
A4266	A4269	Sterilization w/Birth Control
D0120	D9974	Routine Dental Exam
G0155	G0156	Home Health Hospice
G0396	G0397	Substance Abuse
J7300	J7306	Sterilization w/Birth Control
S5100	S5101	Adult Day Care
S9434	S9434	Food Supplements
V2020	V2799	Vision Services
V5000	V5999	Hearing Aids
Various		HIV Medications

Beg Rev	End Rev	Code Category
100	999	Extended or Long Term Care Facility
990	999	Personal Convenience Items for Inpatient

APPENDIX E – MSN PROGRAM CONTRACTED CLINICS by CITY

All MSN Enrollees' are assigned to a Community Clinic for necessary follow-up care during their enrollment period. The Community Clinic will work the MSN CCU to coordinate any necessary specialty referrals.

MSN Clinic Resource Name	Street	City	Phone
Alta Med Healthcare Services	1814 West Lincoln Avenue	Anaheim	(888) 499-9303
Central City Community Health Center - Anaheim	2237 West Ball Road	Anaheim	(714) 490-2750
KCS Health Center	7212 Orangethorpe Avenue, Suite 9A	Buena Park	(714) 503-6550
Share Our Selves	1550 Superior Avenue	Costa Mesa	(949) 270-2100
Families Together of Orange County	24582 Del Prado Ave. #H	Dana Point	(714) 665-9890
North Orange County Regional Health Foundation	901 West Orangethorpe Avenue	Fullerton	(714) 441-0411
Sierra Health Center	501 South Brookhurst Road	Fullerton	(714) 870-0717
St. Jude Neighborhood Health Center	731 South Highland Avenue	Fullerton	(714) 446-5100
Alta Med Healthcare Services	12751 Harbor Boulevard	Garden Grove	(888) 499-9303
Nhan Hoa Comprehensive Health Center	7761 Garden Grove Boulevard	Garden Grove	(714) 898-8888
VNCOC (Asian Health Center)	9862 Chapman Avenue	Garden Grove	(714) 418-2040
Alta Med Healthcare Services	8041 Newman Avenue	Huntington Beach	(888) 499-9303
Friends of Family	501 South Idaho Street, Suite 190	La Habra	(562) 690-0400
The Gary Center	341 Hillcrest Street	La Habra	(562) 691-3263
Laguna Beach Community Clinic	362 Third Street	Laguna Beach	(949) 494-0761
Share Our Selves	307 Placentia Avenue, Suite 107	Newport Beach	(949) 270-2100
Alta Med Healthcare Services	4010 East Chapman Avenue	Orange	(888) 499-9303
Center for Inherited Blood Disorders	1010 West La Veta Avenue, Suite 670	Orange	(714) 221-1200
La Amistad de Jose Family Health Center	353 South Main Street	Orange	(714) 771-8006
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	(949) 240-2272
Alta Med Healthcare Services	1400 North Main Street	Santa Ana	(888) 499-9303
Alta Med Healthcare Services	2720 South Bristol Street, Suite 110	Santa Ana	(888) 499-9303
El Sol Wellness Center	1014 North Broadway	Santa Ana	(949) 270-2100
Serve the People	1206 East 17th Street, Suite 101	Santa Ana	(714) 352-2911
Central City Community Health Center - Stanton	12116 Beach Boulevard	Stanton	(714) 898-2222
Livingstone CDC	12362 Beach Boulevard, Suite 10	Stanton	(714) 248-9500
Families Together of Orange County	661 West First Street, Suite G	Tustin	(714) 665-9890
Orange County Rescue Mission (Hurtt Family Clinic)	One Hope Drive	Tustin	(714) 247-0300

APPENDIX F – MSN PROGRAM NETWORK HOSPITALS by CITY

MSN Network Hospitals provide emergency and scheduled inpatient and outpatient services to MSN Enrollees.

MSN Network Hospital Resource Name	Street	City	Phone
Anaheim Global Medical Center	1025 S. Anaheim Boulevard	Anaheim	(714) 533-6220
West Anaheim Medical Center	3033 W. Orange Avenue	Anaheim	(714) 827-3000
Fountain Valley Regional Hospital & Medical Center	17100 Euclid Street	Fountain Valley	(714) 966-7200
Orange Coast Memorial Medical Center	9920 Talbert Avenue	Fountain Valley	(714) 378-7000
St. Jude Medical Center	101 E. Valencia Mesa Drive	Fullerton	(714) 871-3280
Garden Grove Hospital & Medical Center	12601 Garden Grove Boulevard	Garden Grove	(714) 537-5160
Huntington Beach Hospital	17772 Beach Boulevard	Huntington Beach	(714) 843-5000
La Palma Intercommunity Hospital	7901 Walker Street	La Palma	(714) 670-7400
Mission Hospital - Laguna Beach	31872 Coast Highway	Laguna Beach	(949) 499-1311
Saddleback Memorial Medical Center – Laguna Hills	24451 Health Center Drive	Laguna Hills	(949) 837-4500
Long Beach Memorial	2801 Atlantic Avenue	Long Beach	(562) 933-2000
Mission Hospital Regional Medical Center	27700 Medical Center Road	Mission Viejo	(949) 364-1400
Chapman Global Medical Center	2601 E. Chapman Avenue	Orange	(714) 633-0011
St. Joseph Hospital - Orange	1100 W. Stewart Drive	Orange	(714) 633-9111
Saddleback Memorial Medical Center – San Clemente	654 Camino De Los Mares	San Clemente	(949) 496-1122
Orange County Global Medical Center	1001 N. Tustin Avenue	Santa Ana	(714) 953-3409
South Coast Global Medical Center	2701 Bristol Street	Santa Ana	(714) 754-5558

APPENDIX G – MSN CONTRACTED ED & STABILIZATION CARE HOSPITALS by CITY

MSN Contracted ED & Stabilization Care Hospitals provide only emergency medical services to MSN Enrollees. In certain cases, these hospitals may provide inpatient care and follow-up care to MSN Enrollees.

MSN Emergency and Stabilization Hospital Resource Name	Street	City	Phone
Anaheim Regional Medical Center	1111 W. La Palma Avenue	Anaheim	(714) 999-6161
Kaiser Foundation Hospital - Anaheim	3440 E. La Palma Avenue	Anaheim	(714) 644-6850
Hoag Memorial Hospital - Irvine Campus	16200 Sand Canyon Avenue	Irvine	(949) 517-3167
Kaiser Foundation Hospital - Irvine	6640 Alton Parkway	Irvine	(949) 932-2882
Los Alamitos Medical Center	3751 Katella Avenue	Los Alamitos	(562) 799-3116
Hoag Memorial Hospital Presbyterian	One Hoag Drive	Newport Beach	(949) 764-4624
University of California Irvine Medical Center	101 City Drive South	Orange	(714) 456-7328
Placentia Linda Hospital	1301 North Rose Drive	Placentia	(714) 993-2000

APPENDIX H – USE OF CRITICAL CARE CODES (99291 – 99292)

Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organs such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life threatening deterioration of the patient's condition.

Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiological parameters and/or application of advanced technologies, critical care may be provided in life threatening situations when these elements are not present.

MSN will pay for critical care services reported with CPT codes 99291 and 99292 when the illness or injury AND the treatment provided meet the above requirements. Participating MSN hospitals should submit critical care claims as paper claim (UB04 or UB92) AND include all pertinent notes.

Critical care claims without substantiating documentation will be automatically "down-coded" to a standard emergency room visit code.

APPENDIX I – PERMANENT RESIDENTS UNDER COLOR of LAW (PRUCOL)

Noncitizens who are PRUCOL may include, but are not limited to:

- Refugees, asylees, and persons granted withholding of deportation or removal
- Parolees and Cuban/Haitian entrants
- Conditional entrants
- Lawful temporary residents under the amnesty programs
- Persons granted deferred action status
- Persons granted deferred enforced departure (DED)
- Persons granted Family Unity
- Applications for adjustment of status who are immediate relatives of US citizens
- Persons under an order of supervision
- Persons granted stays of deportation or removal
- Noncitizens who have continuously resided in the US since before January 1, 1972
- Certain battered immigrants, parents of battered children
- Citizens of Micronesia, the Marshall Islands, or Palau
- Persons granted K, S, U, or V status
- Victims of trafficking
- Persons granted voluntary departure

APPENDIX J – OUT-of-AREA PROVIDERS and REIMBURSEMENT

The MSN Program may provide reimbursement for emergency services and necessary post-stabilization care provided to MSN Enrollees outside of Orange County, California. MSN requests that your hospital notify the MSN Care Coordination Unit at (714) 834-3557 within 72 hours of the initial encounter.

While notification for emergency services is not mandatory, this will allow for the issuance of any needed authorizations, transfer and/or discharge planning for the MSN Enrollee. Face sheets and clinical documentation can be faxed to MSN at (714) 834-6292. Upon notification, CCU will issue an authorization number. This number should be included on all claims (hospital, physician, and ancillary) relating to the episode of care.

Any Out-of-Area provider seeking reimbursement must complete the MSN Registration process and agree to the MSN Conditions of Participation and the terms and conditions of the MSN Fiscal Intermediary Agreement. Registration can be done online at ***https://ochca.amm.cc/register.aspx***. If you need assistance with registering, please contact Advanced Medical Management at (800)206-6591 during normal business hours.

Reimbursement rates for non-contract providers are set forth in the MSN Fiscal Intermediary Agreement and is available for download at www.ochealthinfo.com.

Out-of-Area Hospitals

Non-Contract Hospital Reimbursement Rates
Inpatient Rate: 45% of the lowest 2010 CalOptima rate for Orange County hospitals.
Outpatient/ED Services Interim Rate: 45% of CalOptima Fee-For-Service rates by CPT code.
Implantable Devices: 70% of the invoice cost for implantable devices. Must include copy of the implant invoice with your claim.

Out-of-Area Physicians

Out-of-Area Physician Reimbursement Rates
Reimbursement: 95% of CalOptima Fee-For-Service rates by CPT code.

Please note the MSN Program covers only urgent and emergent medical services necessary to prevent the loss of life, limb, and to prevent permanent disability.

MSN Provider Relations is available to answer any additional questions you may have. Please contact them at (714) 834-3557.

APPENDIX K – MinuteClinics by City

MinuteClinics	Street
Aliso Viejo	26891 Aliso Creek Road, Aliso Viejo 92656
Buena Park	8850 Valley View Street, Buena Park 90620
Costa Mesa	1150 Baker Street, Costa Mesa 92626
Huntington Beach	19121 Beach Blvd., Huntington Beach 92648
Irvine	14330 Culver Drive, Irvine 92604
Mission Viejo	25272 Marguerite Pkwy., Mission Viejo 92692
San Clemente	638 Camino De Los Mares, San Clemente 92673
Seal Beach	921 Pacific Coast Highway, Seal Beach 90740
Yorba Linda	18080 Imperial Highway, Yorba Linda 92886