



MEDICAL SERVICES INITIATIVE (MSI) PROVIDER MANUAL

**15th Edition
March 2012**



**HEALTH CARE AGENCY
MSI**

**P.O. Box 355
SANTA ANA, CA 92702**

Website

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

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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 primary and specialty medical care for Orange County eligible residents 19 through 64 years of age who have no other resource for medical care.

The MSI program structure includes the County of Orange and private medical community in a unique public-private partnership to deliver health care to qualified Orange County residents utilizing the entire medical system and resources.

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 Administration at (714) 834-6248, and ask that your name and e-mail address be added to the distribution list.

MSI has brochures and patient handbooks available in English, Spanish, and Vietnamese. These useful tools are available on the MSI Website or by calling the MSI Patient Education Department at (800) 417-4262.

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 the 1115 Medicaid Waiver

Since September 2007, MSI has operated under an 1115 Medicaid Waiver. The first waiver, "Coverage Initiative," allowed MSI to expand coverage to include primary and preventive care. The latest waiver, known as the "Low Income Health Program" or "LIHP" will allow MSI to continue its expansion of benefits to include podiatry and limited mental health services.

Under the newest waiver, MSI applicants no longer require a medical condition to apply.

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 within the first thirty (30) days of their eligibility period and, after that, once every six months.

New MSI members receive a Notice of Action (NOA) letter with an attached member identification card. The document contains the Member's unique ID number, Medical Home assignment, the Provider on-line eligibility/medical home verification system

website, pharmacy co-pay (if applicable), and phone numbers for the Authorization Department, the Nurse Advice Line, and the Patient Education Department (PED).

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."*

Furthermore, MSI contracted hospitals must comply with the terms and conditions of their executed agreement with the County of Orange. **MSI is a countywide program and as such patients may be referred to any participating provider within the MSI network.**

The County of Orange DOES NOT recognize "catchment" areas or geographic restrictions enacted by MSI providers. The MSI Program will investigate all instances of service denials based on an MSI member's city or neighborhood of residence.

Out-of-network emergency services and post stabilization care are covered for MSI members. MSI Authorizations must be notified within twenty-four (24) hours of admission or treatment for services to be covered. Out-of-Network hospitals must register as a condition of reimbursement and agree to the MSI Conditions of Participation before any reimbursement will be made.

IMPORTANT PHONE NUMBERS

Verify Patient Eligibility On-line & Medical Home Assignment: www.ocmsipov.com

MSI 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 or (866) 613-5178
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Advanced Medical Management (AMM)
Attention: MSI Program
P. O. Box 30248
Long Beach, CA 90853 (800) 206-6591

Fiscal Intermediary/Claims Services (800) 206-6591

Recovery Agent Services (800) 206-6591

Comprehensive Care Solutions, L.L.C.

4600 Campus Drive, Suite 104
Newport Beach, CA 92660

Authorizations (Inpatient, Outpatient, Rx Prior Authorization) (714) 784-4711
Fax: (714) 784-7475

24/7 Nurse Advice Line (Patients Only): (800) 381-9221

Patient Education Dept (Patients Only): (800) 417-4262

Outpatient Case Management: (800) 417-4262

Social Services Agency (SSA) Eligibility Information Line (866) 979-6772

Hospital Association of Southern California (HASC) (714) 750-0788

12361 Lewis Street, Suite 101
Garden Grove, CA 92840

Coalition of Orange County Community Clinics (COCCC) (949) 486-0458

17701 Cowan Avenue, Suite 220
Irvine, CA 92614-6057

II. PROGRAM SERVICES

A. Medical Homes

A Medical Home is intended to go beyond that of a PCP, providing "patient-centric care that is comprehensive, continuous, integrated, and optimally meeting the health care needs of the patient across healthcare settings. The goal of a Medical Home is to provide the patient with a broad spectrum of care, both preventive and curative, and coordination of the care the patient receives at the primary care level.

Having a medical home has been shown to substantially improve access to needed care, receipt of routine preventive screenings, and management of chronic conditions.

All MSI patients are assigned to one of over 250 Medical Homes throughout the County. An updated list of participating Medical Homes is located on the provider website at: <http://www.ochealthinfo.com/medical/msi/>. If you would like to participate as a Medical Home, please send your request via e-mail to Shelley Vrungos at svrungos@ochca.com. Providers participating in this program will be included in the annual Quality and Outcomes Framework pool of funds distributed to all Medical Homes based specific measures at the end of each program year. If you would like more details on these measures, please contact MSI Administration at (714) 834-6249.

1. Medical Home — Provider Enrollment Protocol

- a) In order to participate as a Medical Home, the provider must be registered with the MSI Program annually. If the provider is not registered or needs to re-register, the provider must go to the following website to complete the process: <https://ochca.amm.cc/register.aspx>.
- b) The MSI Program requires notification in writing – via mail or e-mail – from providers requesting participation or withdrawal as a Medical Home. E-mail notices can be sent to Shelley Vrungos at svrungos@ochca.com. A provider or group can generally be added as a Medical Home within 72 hours once credentialing has been completed.
- c) 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.
- d) 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.

e) In the event a Medical Home Provider needs to take a temporary leave of absence, a written statement with information about length of absence, and substitute physician coverage must be submitted, in writing, to the MSI Program. The correspondence should be sent via e-mail to Shelley Vrungos at svrungos@ochca.com.

2. Medical Home Policy

MSI members must have an assigned Medical Home. Primary care services rendered by an unassigned Medical Home provider will be denied reimbursement. It is important to verify patient eligibility and Medical Home status at each office visit. This information is available at the following website: www.ocmsipov.com.

Members may change their Medical Home within the first thirty (30) days of eligibility and after that, once every six (6) months. The Medical Home may be changed more often in some circumstances. To change a Medical Home, the Member should call the Patient Education Department (PED) at (800) 417-4262 Option 1. Emergency Department staff may view an MSI member's Medical Home status at the following website: www.erconnect.com.

Effective September 1, 2010, a non-initial visit with a patient having a single diagnosis cannot be billed higher than CPT: 99213. Providers billing CPT codes higher than 99213 should submit clinical documentation justifying the higher code.

3. *MSIConnect* (ClinicConnect and CommunityConnect)

MSI makes patient information available to MSI Medical Home Providers through the MSI Connect portal. This easy-to-use, online system:

- Allows Medical Home providers to see a list of assigned patients, their clinical data (including history), imaging and laboratory results and medication information.
- Enhances access to and improve the continuity of care.
- Improves operational efficiency for Providers.
- Improves provider connectivity and move participants closer to meeting the national standards for “meaningful use.”
- Allows Medical Home providers to participate in the annual Quality and Outcomes Framework pool, which incentivizes the adoption of Health Information Technology (HIT) and use.
- Helps maximize County resources by eliminating unnecessary referrals and duplication of services.

- If you haven't requested **MSIConnect** access, we ask that you do so now. The forms are available on the MSI provider website: www.ochealthinfo.com/medical/msi/providers/news.

4. Co-pay

There are no co-pays for any primary, specialist, or urgent care visits.

B. Authorization Department

This department is responsible to assist Medical Home providers with requests for specialty services and to authorize the following:

- Specialty Physician Services (including Surgical Procedures)
- In-patient Hospital Stays
- Chemotherapy/Radiation Therapy
- Skilled Nursing Facility
- Sleep Studies
- Physical Therapy/Occupational Therapy
- In-Home Health Care
- Durable Medical Equipment (DME)
- High dollar diagnostic procedures, including MRI, PET Scan, CT Scan

1. Authorization Process:

All non-urgent requests must be submitted in writing to the Authorization Department on the MSI Referral Request Form. The form is available on the Provider website: www.ochealthinfo.com/medical/msi/providers/news.

The form must be sent via fax to:

(714) 784-7475

Included clinical information should not exceed three (3) pages.

Urgent referrals may be requested by phone: (714) 784-4711.

The Referral Request form is sent back to the requesting provider with the disposition of the request. If approved, the authorization number and all other pertinent information will be noted on the form. The requesting provider is responsible to relay all necessary information (including clinical records, if appropriate) to the respective specialist or specialty service entity/to the patient.

Each authorization for specialists is good for three (3) visits unless otherwise indicated. Surgical procedures require a separate authorization number. Unless urgent, the patient is directed back to the Medical Home after the third visit. If a specialist visit is required at a later date, the Medical Home requests authorization.

Note: *If after the third visit, the patient still requires medication adjustment or further diagnostic evaluation and/or treatment, the specialist may request an additional authorization directly from the Authorization Department. It is important the specialist inform the patient's assigned Medical Home provider of the patient's medical status.*

Authorization numbers must be entered in box 23 of the CMS-1500 form.

The following diagnostic services do not require authorization:

- Laboratory
- General X-ray
- Mammograms
- Barium Enema
- Barium Swallow
- Intravenous Pyelogram (IVP)
- Routine ultrasound (non-invasive)
- Radiological biopsy (incisional biopsies require authorization)
- Doppler studies
- Pulmonary Function Tests
- Cardiac Stress Tests
- EKG
- Treadmill
- Stress Echo
- Nuclear Studies (when performed in specialty setting)
- Specific services in your Letter of Agreement (some specialties only).

The following diagnostic procedures require authorization and should not be performed in a Primary Care setting:

- Incisional biopsies

- Vascular Doppler exams of the upper or lower limbs, including carotids
- Holter studies
- Echocardiograms (Doppler or trans thoracic)
- Ultrasounds of the breasts, abdomen, pelvis, or thyroid
- Radiological services – skeletal x-rays, CXR, abdominal & pelvic X-rays

See Appendix A.1 for more information about covered and non-covered services.

2. Appeal Process for Denied Requests:

- Authorization Department staff returns referral request form with reason for denial: lack of documented medical necessity or out of MSI scope of services.
- Patients have the right to appeal denials for specialty services. MSI will send a letter to directly to the patient advising them of the denial, the reason, and their right to appeal the decision. Physicians have the right to appeal the denial on the patient's behalf and can do so by contacting MSI at (714) 834-3589.
- Incomplete or incorrect referral requests will be cancelled and should be resubmitted with the correct documentation.

III. OUTPATIENT SERVICES

A. Laboratory

Quest Diagnostics has a capitated agreement with the MSI Program to provide outpatient laboratory services.

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.
- Genetic typing to determine risk factors for disease—***Genetic typing may be covered if disease is suspected and typing is necessary to confirm diagnosis and/or determine treatment.***

- Preoperative tests for surgical procedures not covered under the MSI program. **Refer to Appendix A.1 for more information about covered and non-covered services.**
- Tests not related to documented diagnoses

B. Imaging

West Coast Radiology has a capitated agreement with the MSI Program to provide MRI, MRA and CT scan services; **prior authorization is required.** Refer to Authorization Department/Appendix A.1 for more information.

Note: Hospitals may continue to provide laboratory and imaging services on an outpatient basis. Hospitals are not required to refer patients to the capitated providers but do have the option to refer patients to them. If the procedures are provided in a hospital setting, they will continue to be reimbursed through the MSI Hospital Agreement via the Point System.

C. 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

Aliso Viejo

South Coast Medical Group

5 Journey, Ste. 130
 Aliso Viejo, CA
 (949) 360-1069
 Mon – Fri: 8 a.m. to 7 p.m.
 Sat: 9 a.m. to 3 p.m.
 Sun: 10 a.m. to 3 p.m.

Anaheim

Gateway Urgent Care

1006 W. La Palma Ave.
 Anaheim, CA
 (714) 778-3838
 Mon – Fri: 8 a.m. to 10 p.m.
 Sat & Sun: 9 a.m. to 5 p.m.

Urgent Care Centers (continued)

Anaheim

OC Urgent Care

631 S. Brookhurst St.
Anaheim, CA
(714) 991-5700
Mon – Fri: 10 a.m. – 6 p.m.
Sat: 10 a.m. – 6 p.m.

Buena Park

Caceres Medical Group

8585 Knott Ave., Ste. 101
Buena Park, CA
(714) 821-8588
Mon – Fri: 8 a.m. to 5 p.m.
Sat: 8 a.m. to 12 p.m.

Foothill Ranch/Lake Forest

OC Urgent Care

26781 Portola Parkway, Ste. 4E
Lake Forest, CA
(714) 991-5700
Mon – Fri: 10 a.m. – 6 p.m.
Sat: 10 a.m. – 6 p.m.

Huntington Beach

Huntington Beach Urgent Care

17752 Beach Blvd, Ste. 203
Huntington Beach, CA
(714) 841-1040
Mon – Fri: 8 a.m. to 8 p.m.
Sat & Sun: 9 a.m. to 6 p.m.

Irvine

Bishop Karras Community Clinic Urgent Care

18021 Sky Park Circle, Bldg 68, Ste. H
Irvine, CA 92614
(949) 260-0746
Mon – Fri: 24 hours
Sat & Sun: 24 hours

Orange

Sunrise Multispecialty Medical Center

867 S. Tustin Ave.
Orange, CA
(714) 771-1420
Mon – Fri: 7 a.m. – 10 p.m.
Sat & Sun: 9 a.m. – 5 p.m.

San Juan Capistrano

Partners In Health

32241 Camino Capistrano, Ste. A-105
San Juan Capistrano, CA
(949) 661-6555
Mon – Fri: 8 a.m. to 5 p.m.
Sat & Sun: CLOSED

IV. ELIGIBILITY VERIFICATION

An MSI Provider On-Line Verification (POV/and Medical Home Status) system is available 24 hours, 7 days a week for verification of patient eligibility. To access this system, go to <http://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 thirty- (30) day period only) and Suspended Eligibility (eligibility on temporary hold and claims not payable until case investigation is complete).

Additionally, the POV site will provide you with the patient's current assigned Medical Home and Medical Home history. 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 and should do so within forty-five (45) days of their eligibility end date.

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 sixty (60) days of the date on the Notice of Action. The County is solely responsible for conducting these hearings.

Temporary Eligibility (TE)

Thirty (30) 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 (12) months of coverage and if appropriate, may include retroactivity of up to three (3) months. If it is determined the patient does not qualify for the MSI program, eligibility will discontinue at the end of the thirty- (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 the Authorization Department: (714) 784-4711)

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

- Hospital notifies the Authorization Department 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 post-discharge medical care.

Note: Exceptions to the above criteria must be approved by the MSI Medical Director or their designee

Outpatient: (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

- The MSI Program follows Medicare billing rules.
- Any changes in the Medicare codes, fee schedule, or processing rules, are implemented with the start of the new MSI program year (July 1).
- MSI, like Medicare, does not recognize preventive care codes. Preventive services should be billed as an office visit.

Advanced Medical Management (AMM) currently serves as the Fiscal Intermediary for the MSI program. The timeline for claims submission is ninety (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 may vary from year-to-year. The only exception to this rule applies to retroactive enrollment. Physicians must use a CMS-1500 Form for claims submission. Electronic submissions are preferred. All claims 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
- Authorization (if applicable)
- 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) or verify their eligibility at www.ocmsipov.com.
- 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 held for payment and processed at a later date.

A. Billing by Hospitals

Per the MSI Hospital Agreement, participating Hospitals must notify the Authorization Department, all admissions of eligible/pending MSI patients within twenty-four (24) hours of the admission.

Hospitals must submit the required data to the Authorization Department via fax (714) 784-7475 or by telephone (714) 714-784-4711.

Hospitals not currently utilizing eCEDA are encouraged to contact MSI Administration at (714) 834-6248 for information on how to connect to the system.

Note: By contract, hospitals must submit concurrent review/discharge information to the Authorization Department within ten (10) days of any request.

Hospitals must use the UB92 or UB04. All 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 interim credit is given. The value of the initial credit varies from year-to-year.

A final determination of the amounts due to all hospital contractors, adjusted for PIP, are made at the end of the MSI program year and communicated to all hospitals. The notice includes notification to any hospital that has received an overpayment and a demand for immediate repayment due within ten (10) days.

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

RECUPERATIVE CARE (coordinated with HASC)	POINTS
Recuperative Care (Revenue Code 999)	2

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 when the provider fails to bill timely or submits incorrect claims.

Note: Beginning July 1, 2011, PROVIDERS MAY NOT CHARGE ANY co-pay for any primary care visit, specialty care visit diagnostic procedure, surgery, emergency department visit, or inpatient services provided to MSI patients.

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 for MSI pending applicants, 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 register with the MSI program once every two years as a condition for reimbursement. To register, please go to <https://ochca.amm.cc/register.aspx>. August 2011 was the most recent registration period for all physicians, clinics, and ancillary providers.

Claims submitted by physician or community clinic providers who are not registered will be denied. A new claim must be submitted after registration with the MSI. Only the new claim receipt date will be considered for timely filing. Physicians and clinics must use the CMS 1500 and it must contain information mentioned in the General Billing Information Section.

Upon approval of the MSI Program, Advanced Medical Management (AMM) shall reimburse certain physician groups specified by at rates negotiated by the County in the form of a Letter of Agreement (LOA). Letters of Agreement 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 Letters of Agreement to AMM and the Authorization Department.

Note: Laboratory and diagnostic imaging services are capitated with Quest Diagnostics and West Coast Radiology respectively. Medical Home 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 the capitated laboratory or imaging provider 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 the Authorizations Department.

D. Billing for Pharmaceutical Services

The MSI program has a drug formulary. The formulary is available on-line at <http://www.ochealthinfo.com/medical/msi/>.

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 prescribing physician determines that the drug is medically necessary.

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

CVS Caremark Network pharmacies provide eligible pharmaceuticals. A list of participating pharmacies is available on-line at <http://www.ochealthinfo.com/medical/msi/providers/news>.

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 and billed on a CMS-1500 form. Reimbursement of pharmaceutical costs by AMM will be at MSI rates unless otherwise authorized. MSI will provide AMM the reimbursement rates in effect with MSI's PBM and any exceptions.. Claims will not be considered by AMM for payment unless the J-Code and the NDC # are provided on the claim.

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.

- Ambulance companies must indicate diagnosis on the transportation claim.
- Ambulance companies will be reimbursed at 100% of Medi-Cal rates.
- Paramedic services will be reimbursed at 100% of Medi-Cal rates.

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 Authorization Department. Approved claims for medical supplies are reimbursed at either 100% of Medicare or 100% of Medi-Cal rates, whichever is less, for similar items. **(See Appendix A.1 for Scope of Service criteria).**

G. Billing for Home Health Services (HHS)

All Home Health services must be prior authorized by the MSI Program's Authorization Department. 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 Medicare or 100% of Medical rates, whichever is less, for similar services. **(See Appendix A.1 for Scope of Service criteria.)**

VI. POLICY COMMITTEE

Medical Policy Committee (MPC)

The Medical Policy Committee (MPC) works with the MSI Program to set medical policy related to covered treatments and new procedures. The MPC may also consider specialty authorization appeals submitted to the MSI Program.

The Medical Policy Committee is comprised of the following individuals:

- MSI Medical Director serving as the Chair of the Committee
- Physician from the MSI physician community
- Representative from the MSI hospital community
- Representative from the MSI clinic community
- Representatives from the MSI Program

VII. APPEALS

A. Appeal of Denied Claims

Provider questions regarding eligible charges may be referred to the current Fiscal Intermediary, Advanced Medical Management at (800) 206-6591. Appeals must be submitted, in writing using the appeal form included with your Explanation of Benefits (EOB), within thirty (30) days of the notice of denial, to Advanced Medical Management, P.O. Box 30248, Long Beach, CA 90853.

The appeal must be accompanied by records, medical opinions, arguments or other pertinent information the provider believes would be relevant to establish the pertinent facts.

The MSI Medical Director considers the information contained in the claim file to reach his/her final decision which is binding and final. The provider is notified in writing of the final appeal decision.

B. Appeal of Denied Authorization Requests

Providers have the right to appeal denials of specialty authorization requests on behalf of their patients. Forms are available on each Notice of Authorization Denial and at the MSI website. (www.ochealthinfo.com/medical/msi)

Please send written appeals to the following address:

MSI Program
P.O. Box 355
Santa Ana, CA 92702

Appeals must be filed with the MSI Program within sixty (60) calendar days of the date on the Notice of Authorization Denial.

Denied Authorization Appeals Process

Once received, the MSI Program will examine the appeal and provide the patient with a determination within forty-five (45) calendar days of receipt by the MSI Program.

During the examination period, the patient (or their designated representative) have the right to examine all records/documents under consideration during this appeal.

If requested, the patient and/or their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, in person, in writing, or by telephone, during this examination period.

Forty-five (45) days is the standard time for resolution of an appeal. However, if the patients feels that they cannot wait for forty-five (45) days, they may request an expedited resolution of the appeal.

This expedited review may be granted by the MSI Program. If it is not granted, the MSI Program will provide the patient with a written explanation within two (2) calendar days of the request. The appeal will then be handled within forty-five (45) days.

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.

All transfers must be coordinated through the MSI Authorizations Department.

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

- Cardiovascular surgery service
- Burn Center
- 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
- Any pertinent medical reason as determined by the MSI Medical Director, MSI Authorization Department, MSI Patient Relations, or the MSI Administrator

Note: Special Permit Transfers must be approved by the MSI Medical Director, MSI Patient Relations, MSI Authorizations Department, or the MSI Administrator.

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.

APPENDIX A

SCOPE OF SERVICE

MSI is a medical safety-net program for adults aged 19-64. 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
- Non-emergency medical transportation
- Emergency Dental services
- Durable Medical Goods, prosthetics and medical supplies
- Acute psychiatric evaluation as required for triage
- Skilled nursing care
- Sub-acute care

Inpatient and outpatient mental health services provided by Orange County Behavioral Health Services.

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

1. Pregnancy related services including complications of pregnancy (exception: urine "dip stick" to test for pregnancy)

APPENDIX A—*continued*

2. Extended or long-term care facility service
3. Eyeglasses, eye appliances, hearing aids
4. Routine injections of antigen to ameliorate allergic conditions
5. Adult day care health services
6. Acupuncture/chiropractic services
7. Voluntary sterilization and birth control
8. Inpatient and outpatient alcohol and drug rehabilitation
9. Diagnostic and therapeutic services for male and female fertility
10. Organ transplant (Refer to Medi-Cal)
11. Radial Keratotomy and other laser surgeries to correct refractive impairments
12. All diagnostic, therapeutic and rehabilitative procedures and services which are considered experimental or of unproven medical efficacy
13. Cosmetic procedures (exception: reconstructive surgery, post mastectomy)
14. Personal convenience items for inpatient stay
15. Bariatric surgery
16. Ultrasound, massage and therapeutic thermal packs

APPENDIX A.1

MEDICAL SERVICES INITIATIVE SCOPE OF SERVICE GUIDELINES

INTRODUCTION

The following services require authorization:

- In-Patient hospital
- Specialty physician services
- Skilled Nursing Facility
- Sleep Study
- Physical Therapy/Occupational Therapy
- In-Home Health Care
- Durable Medical Goods
- Diagnostic procedures, including MRI, PET Scan, CT Scan
- Dialysis
- Chemotherapy

Refer to Authorization Department page – for additional information.

Claims without an authorization number ***are processed as follows:***

1. Hospital Days – Inpatient and Emergency Department
 - a. Paid. This includes professional services performed for the same episode of care.
 - b. Hospitals should notify MSI Authorizations as within twenty-four (24) hours of any inpatient admission of an MSI Eligible patient.
 - c. Authorizations for inpatient admissions are done on a concurrent basis.
 - d. Authorizations for Emergency Department are not required.
2. Hospital Days – Outpatient
 - a. Denied. This included professional services performed for the same episode of care.
 - b. Authorization is done on a prospective basis.
3. Specialty Physician Services
 - a. 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 supercedes the LOA rate.

APPENDIX A.1—*continued*

- b. Authorization is done on prospective basis.
 - c. Sub-authorizations are allowed. For example, a referral to an orthopedist automatically allows for authorization of radiological services, or a referral to a cardiologist allows for electrocardiograms, etc.
4. SNF Days
 - a. Denied
 - b. Authorization is done on a prospective basis.
 5. Sleep Studies
 - a. Denied
 - b. Authorization is done on a prospective basis.
 6. Physical Therapy/Occupational Therapy
 - a. Denied
 - b. Authorization is done on prospective basis.
 7. In-Home Health Care
 - a. Denied
 - b. Authorization is done on prospective basis.
 8. Durable Medical Equipment
 - a. Denied
 - b. Authorization is done on prospective basis.
 9. CT and CT/PET scan, MRI, Invasive Imaging
 - a. Denied
 - b. Authorization is done on prospective basis.

The following diagnostic services do not require authorization.

- Laboratory
- General X-ray
- Mammograms
- Barium Enema
- Barium Swallow
- Intravenous Pyelogram (IVP)

APPENDIX A.1—*continued*

- Routine Ultrasound (non-invasive)
- Radiological biopsy (incisional biopsies require authorization)
- Doppler studies
- Pulmonary Function Tests
- Cardiac Stress Tests
- EKG
- Treadmill
- Stress Echo
- Nuclear Studies (when performed in specialty setting)

Note: No authorization is required for primary care, urgent care, or emergency room services

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

BEG DIAG	END DIAG	ICD CATEGORY
367.0	367.9	Disorder of refraction and accomodation
606.0	606.9	Infertility Male
628.0	628.9	Infertility Female
630.0	677.0	Complications of Pregnancy
V20.	V39.	Well Child, Pregnancy, Newborn
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
V79.	V79.9	Special screening for mental disorders and developmental handicaps

APPENDIX A.1—*continued*

Other Services to Note Under the MSI Program Scope:

**DURABLE MEDICAL EQUIPMENT
(Authorization required)**

See Authorization process page.

All Durable Medical Equipment are paid at 100% Medicare rates or 100% of Medi-Cal, whichever is less. 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) Machines:
 - a. ONLY when symptomatology and documented clinical evidence substantiates need. Documented clinical evidence must include:
 - >15 apnea episodes/hour
 - < 84% O₂ saturation level and/or cardiac/pulmonary anomalies or other conditions that may increase the likelihood of severe morbidity or death.
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. O₂ Therapy: (Per Medicare Guidelines)

APPENDIX A.1—*continued*

- a. Payment per month based on rate of 2l/min continuous
 - b. Portable O₂ (E tank) for exercise activity limited to two tanks per month
 - c. Liquid O₂ concentrator, or Large O₂ 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

HOME HEALTH

(Authorization Required – See Authorization Process Page)

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

Excluded:

- Services provided by Home Health Aides or Social Workers.

APPENDIX A.1—*continued*

OUT-OF-COUNTY MEDICAL TREATMENT

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

The MSI Medical Director or 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. There is a fully executed letter of agreement between the MSI Program and the Out-of-County Provider. (Can be waived when emergency treatment is needed.)

This section does not apply to emergency and post-stabilization services previously mentioned.

PHARMACY

Covered:

The MSI drug formulary is available on the MSI website located at the following address: www.ochealthinfo.com/medical/msi/providers/news.

Note: See Appendix D for complete pharmacy information.

PHYSICAL THERAPY

(Authorization Required – See Authorization Process Page)

Covered:

Exercise modalities only when service is billed through a contracted hospital or specialty physician with a valid MSI Letter of Agreement. Physical therapy should be performed at an MSI contracted hospital, the patient's home, or other contracted facility.

Excluded:

- Hot packs
- Massage
- Ultrasound

APPENDIX A.1—*continued*

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
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
30150	30160	Cosmetic Procedure
32851	32856	Transplant-Lung
33930	33945	Transplant-Heart
45560	45560	Elective A&P Repair
47133	47147	Transplant-Liver
48550	48556	Transplant Pancreas
50300	50380	Transplant-Renal
55250	55250	Vasectomy

APPENDIX A.1—*continued*

BEG CPT	END CPT	CODE CATEGORY	
58300	58301	Sterilization w/Birth control	
58600	58615	Sterilization w/Birth control	
58970	58976	In Vitro Fertility Treatment	
59000	59899	Pregnancy	
65710	65755	Transplant-Cornea	
65771	65771	Radial Keratotomy	
69090	69090	Cosmetic Procedure	
90801	90899	Mental Health	Coverage through OC BHS
92551	92597	Audiometry Screening	
95115	95199	Immunotherapy	
97010	97010	Physical Therapy – Hot Packs	
97035	97035	Physical Therapy – Ultrasound	
97124	97124	Physical Therapy – Massage	
97810	97814	Acupuncture	
98940	98943	Chiropractic	
99324	99337	Physician Services LTC	
A4261	A4261	Sterilization w/Birth Control	
A4266	A4269	Sterilization w/Birth Control	
G0155	G0156	Home Health	
J7300	J7306	Sterilization w/birth control	
V2020	V2799	Vision Services	
V5000	V5999	Hearing Aids	
S5100	S5101	Adult Day Care	

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, or any other third-party payer.

The Fiscal Intermediary acts as the recovery agent to pursue reimbursement of claims paid for MSI patients 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, the hospital has the responsibility to reimburse MSI the dollar value of the points to the Fiscal Intermediary. If the hospital discovers 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 must be notified of any third party settlement.

If any Provider (except Skilled Nursing Facilities) receives reimbursement from a third-party settlement or Medi-Cal for services reimbursed, said provider must reimburse the Fiscal Intermediary an amount equal to the MSI payment or the third-party settlement, whichever is less. If an MSI contracted Skilled Nursing Facility (SNF) received reimbursement from a third-party settlement or Medi-Cal, the SNF shall reimburse the Fiscal Intermediary an amount equal to the lesser of the payments received.

All Providers must cooperate with the Fiscal Intermediary in recovering these costs.

Note: Providers must furnish Program's designated recovery agent such records and documentation as reasonably required 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

1. Drug Formulary For MSI (General Information)

The MSI program currently utilizes a closed, generic based 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.

Note: Pharmaceutical co-pays are either \$0 or \$4 depending on the patient's income reported to MSI at the time of application. There is a maximum out-of-pocket expense of \$32 per month.

a. Covered

Medications listed in the MSI drug formulary.

b. Amounts of Medications Dispensed

Limited to a maximum of eight (8) prescriptions per month. Diabetic supplies and certain medication categories are excluded (see maximum 8 exceptions at website noted above). Generic medications must be used whenever possible (no dispense as written) [DAW]. All medications have quantity/dollar limits.

c. Ancillary Pharmacy Items

- Customary ostomy supplies
- Diabetic materials: Insulin syringes and testing materials

Note: The MSI program will 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:

- TrueTrack Helpline (Patients Only) (800) 803-6025
- Pharmacist Helpline (800) 342-7226 x4118
- Physician Helpline (800) 342-7226 x7621

2. Non-Formulary Medications

The MSI Program may cover a non-formulary medication when one of the following conditions is present:

- All formulary options have been ineffective
- Another non-formulary medication is less expensive
- There is overwhelming clinical evidence that the patient will have an improved quality of life
- Diagnosis is within the scope of the MSI program and is consistent with the prescription

APPENDIX C—*continued*

Prescribers who want to request a non-formulary medication must complete an MSI Drug Authorization Request Form. The form is available from the CVS Caremark Customer Support Desk (800) 511-7453 or from the MSI website.

- The form requires input from the prescribing physician or the pharmacist and must include the patient's name, Member Identification number, diagnosis, and pertinent medical information (lab values, failure of other therapeutic agents, etc.) to justify the need for a non-formulary medication.
- Fax a completed Form to MSI Authorizations Department at 714-784-7475 for review.
- The prescribing physician or pharmacist will be notified of the disposition of the review.

Medications not covered through the MSI program may be available through the manufacturer at low or no cost; for more information about this service call Partnership for Prescription Assistance at (888) 477-2669 or go online to <http://www.needymeds.com>.

Note: The MSI Program currently contracts with CVS Caremark for pharmacy management services. A list of participating pharmacies is available on the MSI website and through CVS Caremark Customer Service Desk (800) 511-7453.

Pharmacists who cannot access the CVS Caremark system may call (888) 863-3378 for assistance.

3. Beginning 9/1/2010, pharmaceutical codes for medications administered within a physician's office will be reimbursed at the following rates at Average Sales Price (ASP) + 6% with the following exceptions:
 - a. Pharmaceutical codes without ASP pricing will be reimbursed at Average Wholesale Price (AWP) less 16% (brand) and AWP less 64% (generics) respectively.
 - b. All pharmaceuticals related to Home Health services will be reimbursed at AWP less 16% (brand) and AWP less 64% (generics).

APPENDIX D

MSI COMMUNITY CLINICS

Anaheim

Altamed

1814 W. Lincoln Ave.
Anaheim, 92801
(714) 780-5690

Central City Community Health Center

2235 W. Ball Rd.
Anaheim, 92804
(714) 520-0855

UCI Family Health Center – Anaheim

300 W. Carl Karcher Way
Anaheim, 92801
(714) 456-6401

Costa Mesa

Share Our Selves

1550 Superior Ave.
Costa Mesa, 92627
(949) 270-2100

Fullerton

Reproductive (Sierra) Health Care Center, Inc.

501 S. Brookhurst Rd.
Fullerton, 92833
(714) 870-0717

North Orange County Regional Health Foundation

901 W. Orangethorpe Ave.
Fullerton, CA 92832
(714) 441-0411

St. Jude Hospital Inc. Mobile Health Clinic

731 S. Highland Ave.
Fullerton, 92835
(714) 446-5100

Garden Grove

Altamed

12751 Harbor Blvd.
Garden Grove, 92843
(714) 636-7852

Nhan Hoa Comprehensive Health Center

7761 Garden Grove Blvd.
Garden Grove, 92841
(714) 898-8888

VNCOC (Asian Health Center)

9862 Chapman Ave
Garden Grove, 92841
(714) 418-2040

Huntington Beach

Altamed Community Care Centers

8041 Newman Ave.
Huntington Beach, 92647
(714) 847-4222

Laguna Beach

Laguna Beach Community Clinic

362 Third St., Laguna Beach, 92651
(949) 494-0761

La Habra

Friends of Family Health Center

501 S. Idaho St., Ste. 100
La Habra, 90631
(562) 690-0400

The Gary Center

341 Hillcrest, La Habra, 90631
(562) 691-3263

APPENDIX D—*continued*

MSI COMMUNITY CLINICS

Orange

La Amistad De Jose Family Health

353 S. Main St., Orange, 92868
(714) 771-8006

**Puente A La Salud Mobile Community
Clinic**

363 S. Main St., Suite 204
Orange, CA 92868
(714) 744-8801

Santa Ana

Altamed – Central

1155 W. Central Ave., Ste. 105-107
Santa Ana, 92707
(714) 557-4080

Altamed – Clinic for Women

1227 W. 17th St., Santa Ana, 92706
(714) 500-0340

Altamed – Main

1400 N. Main St., Santa Ana, 92701
(714) 541-6815

Serve The People

1206 E. 17th St., Suite 204
Santa Ana, CA 92701
(714) 352-2911

UCI Family Health Center – Santa Ana

800 N. Main St., Santa Ana, 92701
(714) 456-6401

San Juan Capistrano

Camino Health Center

30300 Camino Capistrano
San Juan Capistrano, CA 92675
(949) 240-2272

Stanton

Central City Community

Health Center
12116 Beach Blvd, Stanton, 90680
(714) 898-2222

Tustin

**Orange County Rescue Mission (Hurt
Family Clinic)**

One Hope Dr., Tustin, CA 92782
(714) 247-0300

APPENDIX D—*continued*

MSI CONTRACTED HOSPITALS

Anaheim

Anaheim General

3350 W. Ball Rd., Anaheim, 92804
(714) 947-5800

Anaheim Regional Medical Center

111 W. La Palma Ave., Anaheim, 92801
(714) 999-6161

Kaiser Foundation Hospital— Anaheim

441 Lakeview Ave., Anaheim, 92807
(714) 279-5459 - (Monday-Friday)
(714) 279-4072 - (weekends only)

West Anaheim Medical Center

3033 W. Orange Ave., Anaheim, 92804
(714) 827-3000 x 5794

**Western Medical Center
Hospital – Anaheim**

1025 S. Anaheim Blvd., Anaheim, 92805
(714) 502-2668

Fountain Valley

**Fountain Valley Regional Hospital and
Medical Center**

17100 Euclid St., Fountain Valley, 92708
(714) 966-3316

Orange Coast Memorial Medical Center

9920 Talbert Ave., Fountain Valley, 92708
(714) 378-7588

Fullerton

St. Jude Medical Center

101 W. Valencia Mesa Dr., Fullerton, 92635
(714) 446-5141

Garden Grove

**Garden Grove Hospital and
Medical Center**

12601 Garden Grove Blvd.
Garden Grove, 92643
(714) 741-2713

Huntington Beach

Huntington Beach Hospital

17772 Beach Blvd., Huntington Beach, 92647
(714) 843-5000

Irvine

**Hoag Memorial Hospital –
Irvine Campus**

16200 Sand Canyon Ave., Irvine, 92618
(949) 517-3167

Kaiser Foundation Hospital – Irvine

6640 Alton Pkwy., Irvine, 92618
(949) 932-2882

Laguna Beach

Mission Hospital – Laguna Beach

31872 Coast Hwy., Laguna Beach, 92677
(949) 347-6040

Laguna Hills

**Saddleback Memorial Medical
Center – Laguna Hills**

24451 Health Center Dr., Laguna Hills, 92653
(949) 452-3177

La Palma

La Palma Intercommunity Hospital

7901 Walker St., La Palma, 90623
(714) 827-3000 x 5794

Los Alamitos

Los Alamitos Medical Center

3751 Katella Ave., Los Alamitos, 90720
(562) 799-3116

APPENDIX D—*continued*

MSI CONTRACTED HOSPITALS

Mission Viejo

Mission Hospital Regional

Medical Center
27700 Medical Center Rd., Mission Viejo, 92691
(949) 347-6040

Newport Beach

Hoag Memorial Hospital Presbyterian

One Hoag Dr., Newport Beach, 92663
(949) 764-4624

Orange

Chapman Medical Center

2601 E. Chapman Ave., Orange, 92669
(714) 633-0011 x 1210

St. Joseph Hospital – Orange

1100 W. Stewart Dr., Orange, 92868
(714) 771-8107

**University of California Irvine (UCI)
Medical Center**

101 City Drive South, Orange, 92668
(714) 456-7328

Placentia

Placentia Linda Hospital

1301 North Rose Dr., Placentia, 92670
(714) 993-2000

Santa Ana

Coastal Communities Hospital

2701 Bristol St., Santa Ana, 92704
(714) 754-5558

Western Medical Center – Santa Ana

1001 N. Tustin Ave., Santa Ana, 92705
(714) 953-3409

San Clemente

**Saddleback Memorial Medical
Center – San Clemente**

654 Camino De Los Mares
San Clemente, 92673
(949) 489-4960

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

<http://www.ochealthinfo.com/medical/msi/providers/news>

APPENDIX E

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

The MSI program **works with the Health Care Agency's Behavioral Health Services** department to provide limited coverage of behavioral health services. The locations listed below are for reference only. **MSI Patients should discuss behavioral health matters with their Primary Care Physician/Medical Home. If you feel that you need immediate help, please contact the numbers below for an evaluation.**

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 E—*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: <http://www.ochealthinfo.com/medical/msi/> or you may request a copy from MSI Administration 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 F

DENTAL COVERAGE

The MSI Program only covers emergency extractions and oral/maxillofacial surgical procedures. Services are provided by some MSI Community Clinics and MSI's community dentist network.

A listing of participating dentists as well as the dental fee matrix is available online at <http://www.ohealthinfo.com/medical/msi/>.

West Coast University provides free dental exams, x-rays, and dental hygiene services to the public at no cost. Interested patients should call 1-877-928-2546 to schedule an appointment. Additional information is available online at

<http://www.westcoastuniversity.edu/wcuclinic>.

APPENDIX G

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.

MSI 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. MSI contract 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 "down-coded" to a standard emergency room visit code.

