

MEDICAL
SAFETY NET
PROGRAM

PROVIDER
MANUAL

2026 Edition



**SPECIALIZED
MEDICAL
SERVICES**

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I. INTRODUCTION

The Medical Safety Net (MSN) Program was established in January 2014 by the County of Orange Board of Supervisors under the direction of the OC 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 medically necessary 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.

CONTACT INFORMATION

MSN Program

P.O. Box 355

Santa Ana, CA 92702

Email: MedSafeNet@ochca.com

Website: www.ochealthinfo.com

Main line

(714) 834-6248

Providers Only

(714) 834-3557

MSN Program Patient Eligibility Online Verification

www.ocmsnpov.com

Patient/Provider Relations/Fraud and Recovery

Patients Only

(714) 834-5211

Fiscal Intermediary/Claims Processing/Recovery Agent Services

Advanced Medical Management, Inc.

Customer Service

(800) 206-6591

Claims submission

Attention: MSN Program

P. O. Box 3689

Long Beach, CA 90853

MSN Program Care Coordination Unit (CCU)/Inpatient

Authorization/Outpatient Authorization

Main Line:

(714) 834-3557

Traditional Authorization Fax:

(714) 564-0959

Electronic Fax (E-Fax):

(714) 564-0432

or MSNRightfax@ochca.com

Pharmacy Benefits Manager- ProCare Rx

Customer Support Line:

(800) 699-3542

MSN PROGRAM FACILITIES

A. Hospitals

Hospitals participating in the MSN Program can 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 applicants for Medi-Cal coverage, commercial insurance, and MSN Program eligibility.
- c. Coordinate with the MSN Care Coordination Unit (CCU) to assist in the evaluation of the enrollee's medical stability and need for continued hospitalization and/or 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-Contracted 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 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 CMATs and screen potential MSN patients for Medi-Cal coverage, commercial insurance, and MSN Program eligibility.
- 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-Contracted Hospitals, including those hospitals located outside of Orange County, must complete the MSN electronic registration at <https://ochca.amm.cc/register.aspx>. Registration as a participating provider is mandatory to receive any reimbursement from the MSN Program.

Non-Contracted 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, or via E-fax at (714) 564-4032 or MSNRightfax@ochca.com.
 - 1. Coordinate with the MSN 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-contracted hospital if a transfer or discharge cannot be arranged.

3. Non-contracted hospitals located outside of Orange County should notify the CCU within seventy-two (72) hours of the enrollee's 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. Registration as a participating provider is mandatory to receive any reimbursement from the MSN Program.
2. Designate one or more staff members to serve as Certified MSN Application Technicians (CMAT) and screen potential MSN applicants for Medi-Cal coverage, commercial insurance, and MSN Program eligibility.
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 (available at www.ochealthinfo.com) to (714) 564-4032 or MSNrightfax@ochca.com.

C. Physicians and Other Providers

Physicians refer to any licensed medical doctor with a practice in Orange County. Other providers include non-contracted hospitals, laboratories, urgent care centers, imaging centers, home health service providers, suppliers of durable medical equipment, ambulance operators or other health care providers as may be authorized by MSN program administration. Under the MSN Program, physicians and other providers delivering care to MSN enrollees are required to perform the following actions:

1. Complete the MSN electronic registration process available at <https://ochca.amm.cc/register.aspx>. Registration is mandatory to receive any reimbursement from the MSN program.
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) covers necessary medical care to Orange County residents who meet the following requirements:

- Urgent or emergent medical condition that, if left untreated, 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 is 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 Modified Adjusted Gross Income (MAGI) Medi-Cal or Traditional Medi-Cal eligibility.
- Compliance with Income Limitations.
- Compliance with Property Limitations.

Family 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. However, the applicant may spend down assets in the encounter month 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 CMAT, the forms are forwarded to the MSN Eligibility Unit for evaluation and processing. Information on the application is verified through various databases and provided documentation.

IV. MSN PROGRAM COVERED and EXCLUDED SERVICES

A. Covered Services

The 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 eligible for reimbursement:

- 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 MSN Program formulary.
- All OTC (Over-the-Counter) Medications.
- Adult daycare 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 use 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, Advanced Medical Management (AMM), 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
MinuteClinic 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 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 visits provided in a single day at any single facility, only one co-payment per day may be collected.
- 6.

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-Contracted 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 after receipt of request. 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, specialty services or follow-up care should be submitted to the CCU via E-fax to (714) 564-4032 or MSNRightfax@ochca.com.

Authorizations for outpatient services, specialty services, or follow-up care should be made by completing the MSN CCU's Authorization Referral Request form (available at www.ochealthinfo.com) and faxing it to (714) 564-4032 or MSNRightfax@ochca.com.

VII. BILLING INFORMATION

Advanced Medical Management (AMM) currently serves as the Fiscal Intermediary for the MSN Program. The timeline for claims submission is **90 calendar days from the date of service** or from the date noted on the Notice of Action (NOA) letter (the eligibility approval letter), whichever is later.

Claims may be submitted by mail or electronically.

Mail Paper 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	65021
ClaimRemedi	MSN01
Gateway/Trizetto	For Professional Claims: AMM13 For Institutional Claims: UMM13

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-10 codes.
- Individual National Provider Identifier (NPI) (if applicable).
- Organizational National Provider Identifier (NPI) (if applicable).

A. Hospital Billing

All hospitals (facilities) may choose to bill electronically or by mail.

All hospital (facility) claims must be billed on a UB04 Claim Form to be eligible for reimbursement.

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.

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 rate (per diem or APR-DRG).
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.

Non-Contracted Hospital Reimbursement Rates (within Orange County)
Inpatient Rate: 45% of the Network Hospital's standard CalOptima rate (per diem or APR-DRG).
Outpatient/ED Services Interim Rate: 45% 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-10 codes on the transportation claim.

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

C. 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 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.

D. 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 reimbursement.

All HHS 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.

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 100% of the prevailing Medicare rate whichever is lower.

E. Billing for Pharmaceuticals

The MSN Program has a drug formulary. The formulary is available online at https://www.ochealthinfo.com/sites/hca/files/2021-05/MSN_Urgent_Formulary_May2021_Website.xlsx

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 (available at www.ochalthinfo.com) 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 MSN Drug Authorization Request Form should be faxed to the MSN Provider Relations Office at (714) 564-0432 or MSNRightfax@ochca.com 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 National Drug Code (NDC) 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 100% of the prevailing Medicare rate whichever is lower.

F. MSN Recovery Program

MSN providers must collect payment from any liable third-party payer for medical services rendered to an MSN enrollee. Third-party payers may include Medi-Cal, liability lawsuits and private insurance. The Fiscal Intermediary (AMM) acts as the recovery agent to pursue reimbursement of claims paid for MSN enrollees 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 payer 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 in its entirety. 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.

MSN routinely performs eligibility checks of its current population against the State's Medi-Cal program. Therefore, if payment was issued to an MSN provider upon MSN's discovery of an enrollee's other coverage for the date of service in question, the MSN provider is responsible for reimbursing MSN the amount MSN paid for the service in its entirety. For example, hospitals will reimburse the MSN Program based on the agreed upon rate (i.e., network, emergency and stabilization or non-contracted). If an MSN provider discovers other coverage through its own efforts, the provider must notify AMM, MSN's Fiscal Intermediary, to coordinate reimbursement.

In cases where an MSN enrollee receives a liability settlement, MSN providers may pursue collection of 100% of their allowable charges. AMM, MSN's 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 AMM such records and documentation as reasonably required in support of third-party revenue recovery activities.

To recover identified funds, the MSN Program, through its Fiscal



Intermediary (AMM), reserves the right to withhold or reduce any future payments due to MSN providers failing to cooperate in the recovery process.

APPENDIX A – PROVIDER CLAIMS APPEALS

Providers have thirty (30) calendar days from the mailing date of the Explanation of Benefits (EOB) to appeal any service or payment denial. Appeals must be submitted in writing using the designated appeal form included with the “Explanation of Benefits” from AMM 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 appeal submission extensions 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.

If an appeal is not submitted within thirty (30) calendar days after the notification of denial, the appeal decision is considered final. Appeal decisions to AMM cannot be appealed again and, if submitted, will not be considered. If an appeal is subsequently denied by AMM, providers may submit an appeal to MSN’s Medical Policy Committee

APPENDIX A – PROVIDER CLAIMS APPEALS (Continued)

(MPC) within thirty (30) calendar days from the appeal denial date. Appeals received after thirty (30) calendar days will not be considered and AMM's determination will be considered final.



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APPENDIX B – MSN PROGRAM SCOPE AND BENEFIT LIMITATIONS

1. Anterior Cruciate Ligament Reconstruction: Only with documented instability of six (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 temporomandibular joint 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. Durable Medical Equipment. 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.



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

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: Eight (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. Inpatient and outpatient mental health, drug use and alcohol services are excluded.
16. NASAL SUBMUCOUS RESECTION is excluded.
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.

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

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-10) CODE

The following diagnoses (ICD-10) are Out of Scope (not an exhaustive list):

ICD-10 Code Range	ICD-10 Category
F01 – F99	Mental Disorders
H52.0 – H52.7	Disorder of Refraction & Accommodation
N46.0 – N46.9	Infertility (Male)
N97.0 – N97.9	Infertility (Female)
Z30-Z3A, P00-P96, O00 – O9A	Pregnancy and Complications of Pregnancy
L84	Diseases of Skin and Subcutaneous Tissue
L60.0 – L60.9 L62	Diseases of Nails
M20.1 – M20.12	Bunion
F10 – F19	Substance Misuse
Z00-Z00.8, Z01- Z01.89	Examinations Without Complaint (e.g., well child, pregnancy)
Z94.0 – Z94.9	Organ or Tissue Transplant
Z30.0 – Z30.9	Contraceptive Management
Z97.3 & Z46.0	Other Devices (e.g., glasses, contacts)
Z46.3 Z46.4	Orthodontic Devices (e.g., dentures)
Z52.0 – Z52.9	Donors
Z59.0 – Z59.9	Problems Related to Housing and Economic Circumstances
F50 – F99 Q90 – Q99	Special Screening for Mental Disorders and Developmental Disabilities
Z00 – Z00.8 Z02 Z02.9	Routine Physical Exams and Other Person Seeking Consultations

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

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

When referencing the procedure codes below, please defer to Appendix B for exceptions to the codes below that may be eligible for reimbursement under the MSN Program.

<u>Beg Cpt</u>	<u>End Cpt</u>	<u>Code Category</u>
11055	11721	All Podiatry Services
11920	11971	Cosmetic Procedure
58555	58565	Sterilization w/Birth Control
15775	15839	Cosmetic Procedure
30400	30630	Cosmetic Procedure
15819	15839	Cosmetic Procedure
19316	19396	Cosmetic Procedure
15876	15879	Cosmetic Procedure
17110	17111	Plantar Wart
30150	30160	Cosmetic Procedure
32850	32856	Transplant-Lung
33927	33945	Transplant-Heart
45560	45560	Elective A&P Repair
47133	47147	Transplant-Liver
48550	48999	Transplant Pancreas
49525	49525	Hernia Repair
50300	50380	Transplant-Renal
55250	55250	Vasectomy
57170	57170	Diaphragm/Cervical Cap Fitting

**APPENDIX D - MSN PROGRAM EXCLUSIONS BY PROCEDURE (CPT) CODES
(continued)**

<u>Beg Cpt</u>	<u>End Cpt</u>	<u>Code Category</u>
57200	57289	Repair Colporrhaphy
58300	58301	Intra-uterine Device (IUD)
58600	58615	Tubal Ligation/Occlusion
58970	58976	In Vitro Fertilization
59000	59899	Pregnancy
65710	65755	Transplant-Cornea
65771	65771	Radial Keratotomy
69090	69090	Ear Piercing
98940	98943	All Chiropractic Services
90785	90785	Mental Health
90791	90792	Mental Health
90832	90899	Mental Health
92550	92596	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	All Chiropractic
99324	99337	Physician Service Long Term Care
99381	99397	Routine Physical Exam
99408	99412	Substance Misuse
99500	99509	Home Health
A0080	A0210	Non-Emergency Transport

**APPENDIX D - MSN PROGRAM EXCLUSIONS BY PROCEDURE (CPT) CODES
(continued)**

<u>Beg Cpt</u>	<u>End Cpt</u>	<u>Code Category</u>
A4261	A4261	Sterilization w/Birth Control
A4266	A4269	Sterilization w/Birth Control
D0120	D0120	Routine Dental Exam
G0155	G0162	Home Health Hospice
G0396	G0397	Substance Misuse
J7300	J7306	Sterilization w/Birth Control
S5100	S5101	Adult Day Care
S9434	S9435	Food Supplements
V2020	V2799	Vision Services
V5000	V5999	Hearing Aids
Various		HIV Medications
<u>Beg Rev</u>	<u>End Rev</u>	<u>Code Category</u>
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 with the MSN CCU to coordinate any necessary specialty referrals.

MSN Clinic	Address	City	Phone
Hurttt Family Health Clinic	947 S. Anaheim Boulevard, Suite 260	Anaheim	(714) 247-0300
Korean Community Services (KCS) Health Center	7212 Orangethorpe Avenue, Suite 9A	Buena Park	(714) 503-6550
Families Together of Orange County	680 Warner Ave. Ste 257 & 353	Fountain Valley	(800) 597-7977
North Orange County Regional Health Foundation	901 West Orangethorpe Avenue	Fullerton	(714) 441-0411
Nhan Hoa Comprehensive Health Center	7761 Garden Grove Boulevard	Garden Grove	(714) 898-8888
Families Together of Orange County	9918 W. Katella Avenue	Garden Grove	(714) 665-9890
Friends of Family	501 South Idaho Street, Suite 190	La Habra	(562) 690-0400
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
Share Our Selves	1 Purpose Drive	Lake Forest	(949) 270-2100
Celebrating Life Community Health Center	27800 Medical Center Road	Mission Viejo	(949) 364-3532
Center for Inherited Blood Disorders	1010 West La Veta Avenue, Suite 670	Orange	(714) 221-1200
Serve the People	1206 East 17 th Street, Suite 101	Santa Ana	(714) 352-2911



MSN Clinic	Address	City	Phone
Hurtt Family Health Clinic	1100 North Tustin Avenue, Suite A	Santa Ana	(714) 247-0300
Livingstone	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	Address	City	Phone
Kaiser Foundation Hospitals	3440 E. La Palma	Anaheim	(714) 644-2000
Anaheim Global Medical Center	1025 S. Anaheim Boulevard	Anaheim	(714) 533-6220
West Anaheim Medical Center	3033 W. Orange Ave.	Anaheim	(714) 827-3000
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	Fullerton	(714) 537-5160
Huntington Beach Hospital	17772 Beach Boulevard	Huntington Beach	(714) 843-5000
Kaiser Foundation Hospitals	6640 Alton Parkway	Irvine	(949) 932-5000
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
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
Saddleback Memorial Medical Center – San Clemente	654 Camino De Los Mares	San Clemente	(949) 496-1122

MSN NETWORK HOSPITAL	ADDRESS	CITY	PHONE
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 – 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 meets the above requirements. Participating MSN hospitals should submit critical care claims as paper claim using the UB04 claim form AND include all pertinent notes.

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

APPENDIX H – 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 I – 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) 564-0432 or MSNrightfax@ochca.com. 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 are available for download at www.ochcahealthinfo.com.

Out-of-Area Hospitals

Non-Contract Hospital Reimbursement Rates
Inpatient Rate: 45% of the lowest 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 J - MinuteClinics by City

MinuteClinics	Address
Buena Park	8850 Valley View Street, Buena Park 90620
Irvine	14330 Culver Drive, Irvine 92604
Seal Beach	921 Pacific Coast Highway, Seal Beach 90740
Yorba Linda	18080 Imperial Highway, Yorba Linda 92886



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