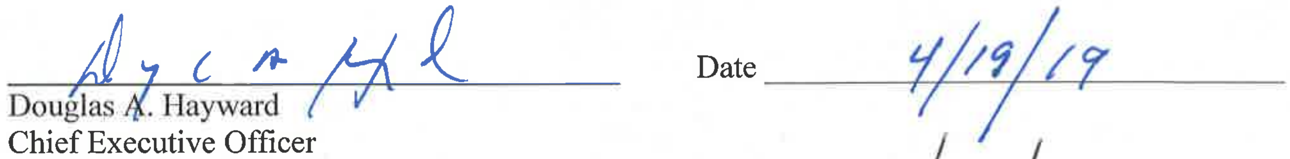
KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: California Children's Services			POLICY #: 3.16-P		
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 05/2000	Review/Revised Date: 04/19/2019	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	



Douglas A. Hayward
Chief Executive Officer
Date 4/19/19

Chief Medical Officer
Date 4/18/19

Chief Operating Officer
Date 4/8/19

Director of Provider Relations
Date 4/4/19

Senior Director of Health Services
Date 4/3/19

POLICY:

Services provided by the California Children Services (CCS) program are carved out of both the contract between Kern Health Systems (KHS) and the Department of Health Care Services (DHCS). These carved out services are therefore not covered by KHS.[1]

KHS is committed to providing optimal care to children. It is important that KHS practitioners/providers (Providers) understand the CCS program to ensure that eligible members are identified at the earliest opportunity. For this reason, KHS educates network Providers regarding

CCS through the use of office orientations, the *KHS Provider Newsletter*, and collaborative training efforts with the local CCS program.

Once a member is accepted by the CCS program, KHS Case Management continues to work with the

CCS Department to coordinate care. The relationship between KHS and the local CCS program is outlined by the Memorandum of Understanding (MOU) with the Public Health Department. Internally, the KHS Director of Health Services is responsible for maintaining a liaison with the CCS Department. KHS provides medical care within its network until medical eligibility for CCS program services is established. Contract Providers provide primary care and other services unrelated to the CCS eligible condition.

KHS tracks members who are in the CCS program for the purpose of utilization and quality management.

PROCEDURES:

1.0 PROGRAM DESCRIPTION[2]

The (CCS) Program is the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions. CCS eligible conditions are those physically handicapped conditions defined in Title 22, California Code of Regulations (CCR) §41515.1[3].

2.0 ACCESS

Members gain access to the CCS program through referrals. Those most likely to identify a potential CCS eligible condition and make a referral are Primary Care Practitioners (PCPs), hospital personnel, KHS Utilization Management (UM) staff, and community agencies or schools. PCPs may identify an eligible condition at the time of the Initial Health Assessment or at any time during routine or follow-up care. PCPs or hospital staff may identify a CCS eligible condition following a premature or complicated delivery, admission for trauma, or other admissions resulting from a CCS condition. Members may also self-refer.

KHS contract Providers are responsible for identifying KHS members with CCS eligible conditions and for making prompt referrals of such members to the local CCS program and to Plan UM staff.

2.1 Referral Process

Referral of CCS eligible conditions by a KHS contract Provider involves notification of both CCS and KHS.

Referrals to the local CCS program may be initiated via telephone, same-day mail, or fax.[4]

Phone: 661-868-0531
Fax: 661-868-0268
Address: 1800 Mt. Vernon Avenue, 2nd Floor
Bakersfield, CA 93306-3302

The initial referral should be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the CCS Program.

Contract Providers must notify the KHS UM Department of members with a potential

CCS condition via a *Referral/Prior-Authorization Form.* (See Attachment to *KHS Policy and Procedure #3.22-P: Referral and Authorization Process*).

3.0 PROVISION OF SERVICES

Services provided by the CCS program are carved out of the contract between KHS and the DHCS. These carved out services are therefore not covered by KHS.[5] KHS does not give prior authorization for payment of services related to CCS eligible conditions. Authorization for such services must be received from the CCS program.

As part of the referral and authorization process (See *KHS Policy #3.22-P: Referral and Authorization Process* for details), UM staff screen all referrals and all admissions on children under the age of 21 for CCS eligible conditions. Upon identification of such conditions, KHS UM staff completes and faxes a *CCS Case Identifying & Locating Information/Initial Referral Information* form and a copy of the *Referral/Prior-Authorization Form* to CCS. (See Attachment A).

Eligible medical conditions for CCS coordination are the responsibility of CCS as determined by the criteria contained within the Numbered Letters for each unique diagnosis. KHS does not determine CCS eligibility but will continue to approve and provide medically necessary services for each member and forward all medically necessary supporting documentation to CCS for review and a final ruling of eligibility. Coordination of services will be a collaborative process between KHS and CCS to ensure member receives appropriate medical care and services without interruptions or barriers.

All potentially CCS eligible conditions will be reviewed for medical necessity and if approved, will be forwarded to CCS for review. Every effort will be afforded to utilize CCS paneled providers to reduce continuity of care issues. If the provider is not KHS contracted, a Letter of Agreement will be drafted to ensure timely and appropriate delivery of care.

KHS provides all medically necessary covered services to the members until CCS eligibility is confirmed.[6] In addition, KHS UM staff continues to follow the care of the member, process referrals for care, and obtain all necessary and required medical documentation from the appropriate providers to facilitate timely evaluation of eligibility by the local CCS program. UM staff refers to the Kern County CCS Provider lists when making referrals to specialists for members with potential CCS eligible conditions. The provider sends medical documentation of the CCS eligible medical condition to the CCS program.

If the member or the specific condition is found to be ineligible for CCS services, KHS remains responsible for the provision of all medically necessary covered services. If the CCS Program denies authorization for any service because the member does not have a CCS eligible condition, KHS remains responsible for obtaining the service, if it is medically necessary and paying for the service if it has been provided.[7]

3.1 CCS Program Services

CCS program services must be provided by CCS paneled/approved providers.

3.1.1 Provider and Member Notification

Notice of Action documents are provided to members and Providers as outlined in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process.*

3.2 Other Services
KHS continues to provide primary care services and other medically necessary covered services unrelated to the CCS eligible condition.[8] UM staff attempt to match members with CCS eligible conditions with CCS Providers to promote continuity of care.

4.0 COORDINATION OF CARE
KHS collaborates with the CCS Program to identify individuals receiving CCS services in order to ensure coordinated service delivery and efficient and effective joint case management between the PCP, CCS specialty providers, and the local CCS Program.[9] KHS collaborates with CCS, the CCS Specialist, and the PCP as necessary to ensure continuity of the member's care. A (MOU) is maintained with the CCS Program for the coordination of services.[10]

4.1 CCS Program Responsibilities
Once CCS medical eligibility is established, CCS Case Managers assume responsibility for case management of the member's CCS eligible medical condition and make any necessary referrals to CCS providers. The CCS Case Manager notifies KHS UM staff, the member, and the specialty care provider of the member's enrollment in CCS. The CCS Case Manager continues to coordinate with the member's PCP and KHS Utilization Management staff to assure continuity of care. CCS staff assist KHS UM staff in identifying and referring members in an efficient and timely manner. As stated in the MOU, CCS staff will maintain at least a 5-day turn-around on CCS eligibility and strive to improve that turn-around time.

CCS notifies KHS if a referral received from another source qualifies for CCS. This notification is by phone or letter.

4.2 KHS Responsibilities
The KHS Director of Health Services is the KHS liaison to the CCS program and through the terms and processes of the MOU assures that KHS members receive CCS services promptly. If a member who is receiving care through the CCS program has a need for ongoing care for a non-CCS eligible condition, KHS UM staff is responsible for facilitating and coordinating that care with the appropriate providers and ensuring that pertinent medical information is shared with the CCS program. UM staff assist CCS staff in obtaining necessary medical information on KHS members and assist in case management activities to provide coordination of care.

4.3 PCP Responsibilities
The PCP identifies the CCS condition, initiates the referral to CCS and the Plan, and provides all necessary medical documentation to assist CCS and the Plan in making a determination. PCPs must perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible condition.[11]

5.0 TRACKING AND MONITORING

Referrals that are identified as being potential CCS eligible conditions are tracked by the UM Department using the CCS Case Identification report. At least monthly[12] meetings between KHS and CCS clinical personnel will be held to ensure timely eligibility determination and financial responsibility for the services rendered. If needed, KHS assists CCS in obtaining outstanding information necessary for an eligibility determination. The CMS SAR system is utilized to research approved or denied decisions rendered by CCS. Updates to the member's treatment plan and authorization history will be completed to ensure accuracy.

5.1 Quality Improvement Chart Review and Quality Focus Review

QI staff select a sample of identified CCS members to include with the QI chart review to monitor and follow up on CCS eligible members as well as monitor the provision of primary care interventions and other medically necessary covered services unrelated to the CCS condition.[13]

6.0 REPORTING

Reporting of CCS monitoring activities is the responsibility of the Quality Improvement Manager. Reports are submitted as outlined in the following table.

Reported To	Report	Due Date
CEO, Chief Medical Officer, Provider Relations Manager, and Director of Health Services	Results of overall chart audits and any related Corrective Action Plans.	Quarterly
QI/UM Committee	Corrective Action Plans	Quarterly

7.0 PROVIDER AND MEMBER EDUCATION

KHS provides CCS information to members via the *Member Handbook* and *Member Newsletter*.

KHS contracted Providers are educated regarding the need to identify members with CCS eligible conditions in order to place eligible members in the most appropriate level of service at the earliest possible time and to limit KHS financial liability for non-covered services.

Contracted Providers receive instructions on CCS program services and eligible medical conditions through Provider Orientations, the *Provider Newsletter*, and educational efforts provided by the local CCS program.

KHS contracted Providers are educated regarding case management and coordination of care through Provider Orientations and in-service meetings along with focus reviews.[14]

8.0 REIMBURSEMENT

CCS reimburses only CCS-paneled providers and CCS-approved hospitals and only from the date of referral.[15] CCS also provides payment for emergency services by non-

paneled CCS providers if:

A. The patient was unstable for transfer, or
B. The facility was unable to transfer to a CCS paneled facility, and
C. Instance A & B must be documented.

For those emergency services denied by CCS as not a CCS eligible condition, providers receive reimbursement from KHS for medically necessary services per KHS policy #3.31-P: *Emergency Services*.

KHS is not responsible for services provided for a CCS eligible condition by either CCS-paneled or CCS-non-paneled providers. Services for CCS eligible conditions are carved out of the contract between KHS and the (DHCS). These carved out services are therefore not the financial responsibility of KHS.

8.1 California Childrens Services (CCS) Coordination of Benefits with Designated Public Hospitals (DPH)

KHS is responsible for providing medically necessary services that are not related to the CCS condition and are carved out under the coverage for the plan benefits. Services provided to a KHS beneficiary with a CCS-eligible condition at a **designated public hospital** are coordinated through the concurrent review process as outlined below:

- If a beneficiary is admitted to a hospital for a CCS-eligible condition, the entire inpatient stay is the responsibility of Medi-Cal Fee-For-Service (FFS), regardless of whether any services provided during that stay are covered by KHS.
- If a beneficiary is admitted to a hospital for a non-CCS-eligible condition, and subsequently receives services during the stay for a CCS-eligible condition, the full stay is the responsibility of Medi-Cal FFS. A Service Authorization Request (SAR) will be authorized by CCS back to the day of admission.
- When a beneficiary stay includes delivery and well-baby coverage under KHS, the entire claim must be billed to KHS. If, during the stay, the baby develops a CCS-eligible condition, the entire stay for the baby will require a SAR from the date of admission and will be the responsibility of Medi-Cal FFS. *Refer to Policy 6.01-P, Claims Submission and Reimbursement and Policy 60.01-I, Claims Submission and Reimbursement for full details of billing requirements.*

8.2 California Childrens Services (CCS) Coordination of Benefits with Private and Non-Designated Public Hospitals (NDPH)

Private hospitals and NDPHs are no longer reimbursed by Medi-Cal FFS on a per diem basis. The Diagnostic Related Group (DRG) methodology now reimburses hospitals for the entire stay of a beneficiary, with payments being higher or lower based on acuity and not on length of stay. Under the DRG system, only an admission SAR or Treatment Authorization Request is required to approve an inpatient stay for beneficiaries under KHS coverage. Therefore, providers cannot bill multiple payers for inpatient stays that includes both managed care and CCS days.

KHS is responsible for providing medically necessary services that are not related to the

CCS condition and are carved out under the coverage for the plan benefits. Services provided to a KHS beneficiary with a CCS-eligible condition at a **private or non-designated public hospital** are coordinated through the concurrent review process as outlined below:

- If the beneficiary is admitted to a hospital for a CCS-eligible condition, the entire stay will be billed to Medi-Cal FFS, regardless of whether any services provided during that stay are covered by KHS.
- If the beneficiary is admitted to a hospital for a non-CCS eligible condition, and subsequently receives services during the stay for a CCS-eligible condition, the full stay will be billed to Medi-Cal FFS. A SAR will be authorized back to the day of admission.
- When a beneficiary stay includes delivery and well-baby coverage under KHS responsibility, the entire stay will be billed to KHS. If, during the stay, the baby develops a CCS-eligible condition, the entire stay for the baby will require a SAR from the date of admission and will be billed to Medi-Cal FFS. KHS will **not** be responsible for the baby's stay. In this case, the hospital will receive two payments. One for the delivery and well-baby stay from KHS and one for the baby under the DRG. *Refer to Policy 6.01-P, Claims Submission and Reimbursement and Policy 60.01-I, Claims Submission and Reimbursement for full details of billing requirements.*

9.0 MEMBER REFUSAL OF CCS SERVICES

If a member refuses CCS services for a CCS eligible condition, it is the provider's responsibility to exercise medical judgment about the next level of intervention, counseling the parent/guardian, involving child advocacy or other appropriate action. KHS will not bill the parent/guardian for CCS eligible services provided outside the CCS program. However, the parent/guardian will be informed by the local CCS program and/or KHS UM staff of their personal financial responsibility for CCS eligible services provided outside the CCS program. KHS UM staff will assist the member and coordinate services if this is the member's informed decision (See Attachment B).

ATTACHMENTS:

- Attachment A: *CCS Case Identifying & Locating Information/Initial Referral Information* form
- Attachment B: *Notification of Member Financial Responsibility for CCS covered services.*

REFERENCE:

Revision 03/2019: Policy reviewed as part of internal review. **Revision 2017-06:** Reference to Designated Public Hospitals and DRG payment methodology added as referenced in APL 16-007 and APL 16-008. [1] **Revision 2014-09:** Bi-monthly meetings changed to "at least monthly" and approved by DHCS. Reference to MRMIB removed. **Revision 2014-03:** Policy revised to comply with 2013 DHCS Medical Audit, deficiency 2.2. **Revision 2011-02:** Routine review, to update phone numbers and address. **Revision 2008-08:** Routine revision provided by the Director of Health Services. **Revision 2006-06:** Revised per DHS Work Plan Deliverable 11.1. **2006-02:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). Includes processes outlined in 2004 CAP Response to Medical Review Audit of 11/2002 to 10/2003. **Revision 2004-05:** Revised Per DHS/DMHC Medical Audit (YEOct03). **Revision 2001-06**: Added Attachments C, D, E, F. Previous Attachment C renamed Attachment G. Revised per DHS Comment Letter (04/30/01).

[1] 2004 DHS Contract Exhibit A – Attachment 11 (8)
[2] 2004 DHS Contract Exhibit E – Attachment 1
[3] California Code of Regulations §41515.1 and 41515.2
[4] 2004 DHS Contract Exhibit E – Attachment 11 (8)(A)(3)
[5] 2004 DHS Contract Exhibit A – Attachment 11 (8)
[6] 2004 DHS Contract Exhibit A – Attachment 11 (8)(A)(4)
[7] 2004 DHS Contract Exhibit A – Attachment 11(8)(A)(6)
[8] 2004 DHS Contract Exhibit A – Attachment 11 (8)(A)(5)
[9] 2004 DHS Contract Exhibit A – Attachment 11 (4) and (8)(A)(5)
[10] 2004 DHS Contract Exhibit A – Attachment 11 (8)(B)
[11] 2004 DHS Contract Exhibit A – Attachment 11(8)(A)(1)
[12] 8/28/2014 Edgar Monroy with the Medi-Cal Managed Care Division approved the monthly meetings as practical, and no compliance issues identified.
[13] Process as described in 2004 CAP Response to Medical Review Audit of 11/2002 to 10/2003.
[14] Process as described in 2004 CAP Response to Medical Review Audit of 11/2002 to 10/2003.
[15] 2004 DHS Contract Exhibit A – Attachment 11(8)(A)(2)

868-0268

CCS CASE IDENTIFYING & LOCATING INFORMATION

[ ] **STAT**

Birthdate:

Sex: [ ] Male [ ] Female

Race:

Birthplace:

Child Also Known As:

Language: [ ] English [ ] Spanish [ ] Other:

CCS#

Medi-Cal

Social Sec.#

KFHC Mbr ID:

Child's Legal Name:

last first middle

Mailing Address:

Residence Address (if differed)

Home Phone#: Message Phone#:

Father's Information:

Name Birthdate Soc. Sec.#

Employer Work# Insurance

Mother's Information:

Name Birthdate Soc. Sec.#

Maiden Name Employer Work# Insurance

Guardians or Foster Parents: Court Worker:

# of Siblings in home: Other Siblings on CCS

Additional Information:

INITIAL REFERRAL INFORMATION

[ ] See Correspondence Section

[ ] See Medical Reports Section

Date of Referral: ______ Received From: ______ at **KFHC** Phone# **664-5093**

Condition:

Treatment Plan:

CPT CODES:

Physician: Paneled: [ ] Yes [ ] No

Other Physicians:

Hospital: Date Admitted: ______ # of days ______

Transferred from: Physician:

Transferred by: [ ] Ground [ ] Air Ambulance company: ______

PCP: ______

Date___________

Dear Parents of ____________

Kern Family Health Care does not cover services provided through the California Children's Services (CCS) program. Your child was referred to CCS because your child had a possible CCS eligible condition that would be covered by CCS. CCS notified us that they had approved a referral for your child to receive the following medical services:

____
____
____

CCS closed your child's case because you did not complete a CCS application or because you did not want to participate in the CCS program. In order for CCS to pay for these services, a signed application must be completed by you and returned to CCS.

This letter is to inform you that, due to State of California Regulations, Kern Family Health Care will not pay for medical services authorized and covered by CCS. It is **very important** that you complete the CCS application process. If you do not want to participate in the CCS program, you will be required to pay all medical bills for your child's medical care that would be covered by CCS.

For assistance in completing the application, please call CCS at (661) 868-0531. You may also call Kern Family Health Care at (661) 664-5093 if you have any questions.

Sincerely,

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros al (800) 391-2000

9700 Stockdale Highway Bakersfield, CA 93311 Fax (661) 664-5190