MEDICAL REVIEW – SOUTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

HEALTH NET COMMUNITY SOLUTIONS, INC.

Contract Number: 03-76812, 07-65847, 09-86157,12-89334
Audit Period: May 1, 2016 Through April 30, 2017

Report Issued: February 2, 2018

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I. INTRODUCTION

Health Net, a wholly owned subsidiary of Centene Corporation, is a managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans.

Health Net offers behavioral health, substance abuse, employee assistance programs, and managed health care products related to prescription drugs. Health Net also offers dental coverage for California State's Healthy Families and Medi-Cal members.

Health Net Community Solutions, Inc. is a subsidiary of Health Net of California, Inc. The State of California's managed care contracts with Health Net of California, Inc. were changed to Health Net Community Solutions, Inc. beginning July 2005. Health Net, Inc. operates in all 50 states and the District of Columbia. Health Net of California, Inc. was licensed in 1991 by the State of California under the Knox-Keene Health Care Service Plan Act of 1975.

Health Net Community Solutions, Inc. delivers care to members under the Two-Plan contracts covering Los Angeles, Kern, San Joaquin, Stanislaus, and Tulare counties; and Geographic Managed Care Plan contracts covering Sacramento and San Diego counties.

As of May 2017, the Plan's enrollment totals for its Medi-Cal line of business are as follows:

Los Angeles	1,000,222
Kern	78,454
San Joaquin	23,053
Stanislaus	75,341
Tulare	112,307
Sacramento	116,924
San Diego	75,444
Total	1,481,745

II. EXECUTIVE SUMMARY

This report presents the audits findings of the Department of Healthcare Services (DHCS) medical review audit for the review period of May 1, 2016 through April 30, 2017. The onsite review was conducted from May 30, 2017 through June 9, 2017. The audit consisted of document review, verification studies, and interview with Plan personnel.

An exit conference was held on December 19, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan delegates Pharmacy Utilization Management (UM) to Molina Healthcare for members within the network in Los Angeles County. The Plan did not report delegated Pharmacy Utilization Management information and data to the Delegation Oversight Committee and the Utilization Management/Quality Review Committee. The Plan did not aggregate, trend, or subject the Pharmacy Prior Authorization data to the Plan's QI process for possible process improvement.

Category 2 – Case Management and Coordination of Care

The Plan's behavioral health treatment guidelines omitted the transition and crisis plan. These guidelines were not consistent with the current DHCS All-Plan Letter 15-025 requirements. The verification study disclosed that 13 treatment plans were missing a transition plan.

Category 3 – Access and Availability of Care

No findings noted during this audit period.

Category 4 – Member's Rights

The Plan's Customer Call Center tree system was not able to detect members' threshold language.

Category 5 – Quality Management

The Plan's policies and procedures were not consistent with contract requirement. According to the Plan's policies and procedures, the Provider Relations department is

required to follow-up with newly contracted Medi-Cal providers within 10 days of being placed on active status to ensure receipt of a welcome-orientation packet and offer in-person training unless waived by the provider. The contract requires the Plan to ensure that all providers receive training regarding the Medi-Cal Managed Care program within 10 days after the Plan places a newly contracted provider on active status.

The verification study review disclosed that nine providers declined the new provider training.

Category 6 – Administrative and Organizational Capacity

No findings noted during this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that medical services provided to the Plan members comply with the federal and state laws, Medi-Cal regulations and guidelines, and State's Two-Plan Contract and Geographic Managed Care Contract.

PROCEDURE

DHCS conducted an on-site audit of the Plan from May 30, 2017 through June 9, 2017. The audit included a review of the Plan's contracts with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan administration and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Request: 26 medical and 14 pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Procedures: 12 appeals were reviewed for appropriateness and decision making in a timely manner.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment: 30 medical records were reviewed for completeness.

Category 3 – Access and Availability of Care

Emergency Service Claims: 16 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 14 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 26 grievances (13 Quality of Care and 13 Quality of Service) and 15 inquiries were reviewed for timely resolution, response to complainant, and appropriate medical decision-making.

Category 5 – Quality Management

Provider Training: 10 new provider training records were reviewed for timely provision of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

No fraud and abuse cases were reviewed for the audit period under review.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: Health Net Community Solutions, Inc.	
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1.5	DELEGATION OF UTILIZATION MANAGEMENT
Delegated Utilization Management (UM) Activities: Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. GMC/2-Plan Contract A.5.5	

SUMMARY OF FINDINGS:

1.5.1 Molina Pharmacy Prior Authorizations

The Contract states that the Plan may delegate Utilization Management (UM) activities. Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. The Plan is responsible to ensure that the UM program includes the integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. (GMC/2-Plan Contracts A.5.1 & A.5.1.G)

Charter #CH-140: Health Net Delegation Oversight Committee mission statement states that the Plan's Delegations Oversight Committee (DOC) purpose is to review previous activities and recommendations from the Delegation Oversight Workgroup (DOW) and to take or recommend appropriate actions to ensure the delegated entities become compliant, maintain compliance and perform adequately to fulfill their contract responsibilities.

As described in the UM/QI Committee Meeting Minutes the DOC is a subcommittee which reports to the UM/QI Committee. The DOC reports important issues to UM/QI for continuous quality improvement and program improvement implementation. The Plan keeps the UM/QI Committee fully aware of all statuses of ongoing activity that the subcommittee has been discussing as continual oversight and monitoring of the delegation program.

The Plan delegates Pharmacy (UM) to Molina Healthcare for members within the network in Los Angeles County. This is the only delegated pharmacy service in the network and includes the Pharmacy prior authorization process.

The UM information and data is not reported to DOC and UM/QI Committee through the Plan's QI process and thus is not being aggregated, trended, or subjected to the QI process for possible process improvement. The Plan's Pharmacy, Envolve Pharmacy Solutions, does control oversight, aggregate, trend, and analyze Molina Pharmacy prior authorization data, but does not forward this to the formal QI process or report to the UM/QI Committee.

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The Plan's lack of oversight and full QI integration of Molina Healthcare Pharmacy prior authorization process may result in missed opportunities for process improvement.

RECOMMENDATIONS:

1.5.1 Develop controls to include the delegated pharmacy prior authorization data in the Plan's QI process, including formal reporting to UM/QI Committee.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.3	BEHAVIORAL HEALTH TREATMENT

Services for Members under Twenty-One (21) Years of Age:
Contractor shall ensure the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and EPSDT Supplemental Services for Members under 21 years of age, including those who have special health care needs. Contractor shall inform Members that EPSDT services are available for
Members under 21 years of age, provide comprehensive screening and prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically
necessary services.
GMC Contract A.10.4

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.
2-Plan Contract A.10.4

ALL PLAN LETTER 15-025: Responsibilities for Behavioral Health Treatment coverage for Children Diagnosed with Autism Spectrum Disorder:
The MCP is responsible for the provision of EPSDT services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions services that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD).

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The MCP must ensure all children receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay.

The MCP is required to:

1) Inform members that EPSDT services are available for members under 21 years of age;
2) Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule
3) Provide access to Comprehensive Diagnostic Evaluation (CDE) based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services.
4) Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
5) Ensure coverage criteria for BHT are met.

For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services respectively.

MCP Approved Treatment Plan:
MCPs must ensure that BHT services are medically necessary and are provided and supervised under an MCP-approved behavioral treatment plan developed by a contracted (or other form of agreement between the MCP and provider) and the MCQMD ALL PLAN LETTER 15-025, Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.

BHT services must be provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. The behavioral treatment plan must be reviewed, revised and/or modified no less than once every six months by a qualified autism service provider.

Continuity of Care (APL 15-025):
MCPs must ensure continuity of care in accordance with existing contract requirements, ALL PLAN LETTER 15-025, and Health & Safety Code Section 1373.96 for the provision of BHT services.

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Delegation Oversight (APL 15-025):
The MCP must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT service.

SUMMARY OF FINDINGS:

2.3.1 Behavioral Treatment Plan Requirements

All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder (ASD) requires that, "The behavioral treatment plan must: Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the beneficiary's progress is measured and reported, transition plan, crisis plan and the individual providers responsible for delivering the services."

The Plan's Applied Behavioral Analysis (ABA) Treatment Plan Review Guidelines, No. 8, states in part, "The treatment plan shall clearly identify the service type, number of hours, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the individual's progress is reported, and the individual providers responsible for delivering the services." The Plan's guidelines omitted the transition plan and the crisis plan. These guidelines are not consistent with the current All Plan Letter 15-025 requirements.

The Plan has a Desk Reference Autism Center ABA Treatment Plan Criteria that the Autism Center program follows in reviewing clinical treatment plans from ABA providers. The Autism Center program uses the Mental Health Network (MHN) ABA Request for Service Authorization Form checklist to process and approve Treatment Plan Criteria. All boxes must be checked to assure a complete Treatment Request. The treatment plans that do not contain all of the elements will not be processed, and returned to the ABA provider for completion. During the interview, the Plan stated that their main focus was continuity of care and to make sure there was no interruption in services.

The verification study of the medical records confirmed that thirteen treatment plans were missing a transition plan. Behavioral Health Treatment (BHT) plan requirements are based on research evidence of effectiveness for the care of individuals who have a diagnosis of ASD. Treatment plans direct the team's approach to services for BHT. When a treatment plans does not contain all required elements, the Plan cannot ensure the BHT services will be effective and as a result, the quality of care may be compromised.

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RECOMMENDATIONS:

2.3.1 Revise and implement the ABA treatment plan guidelines to meet current All Plan Letter requirements.

CATEGORY 4 – MEMBER'S RIGHTS

4.2	CULTURAL AND LINGUISTIC SERVICES

Cultural and Linguistic Program:
Contractor shall have a Cultural and Linguistic Services Program monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the requirements…
GMC Contract A.9.13

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements…
2-Plan Contract A.9.13

Contractor will assess, identify and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).
GMC/2-Plan Contract A.9.13.B

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.
GMC/2-Plan Contract A.9.13.F

Linguistic Services:
Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin.
GMC/2-Plan Contract A.9.12

Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-

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4.2	CULTURAL AND LINGUISTIC SERVICES

speaking or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact…either through interpreters, telephone language services, or any electronic communication options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.
GMC Contract A.9.14.B

Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact…either through interpreters, telephone language services, or any electronic options…
2-Plan Contract A.9.14.A

Types of Linguistic Services:
Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential Members:

1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact.
2) Fully translated written informing materials…
3) Referrals to culturally and linguistically appropriate community service programs.
4) Telecommunications Device for the Deaf (TDD).
5) Telecommunications Relay Service (711) (GMC only)

GMC Contract A.9.14.C/2-Plan Contract A.9.14.B

Key Points of Contact Include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
2) Non-medical care setting: Member services, orientations, and appointment scheduling.

GMC Contract A.9.14.E/2-Plan Contract A.9.14.D

SUMMARY OF FINDINGS:

4.2.1 24-hr Oral Interpreter Services at all Key Points of Contact

The Contract requires the Plan to monitor, evaluate, and take effective action to address any needed improvement in the delivery of linguistically appropriate services.
(GMC / 2Plan Contracts A.9.13)

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The Contract requires the Plan to ensure that all monolingual, non-English-speaking and limited English proficient (LEP) Medi-Cal members and potential members receive 24-hour oral interpreter services at all key points of contact, either through interpreters, telephone language services, or any electronic communication options. The Plan shall ensure that lack of interpreter services does not impede or delay timely access to care.
(GMC Contract A.9.14.B / 2-Plan Contract A.9.14.A)

The Contract describes key points of contact in medical care settings as telephone, advice and urgent care transactions, and outpatient encounters with healthcare care providers including pharmacists; and non-medical care setting as member services, orientations, and appointment scheduling.
(GMC Contract A.9.14.E / 2-Plan Contract A.9.14.D)

Pursuant to Title 22, 53853(c) Accessibility of Services states that each plan shall ensure that members have 24- hour access to interpreter services.

Policy and Procedure HM326-193022: Interpreter Services states that the Plan will provide members/enrollees with access to no-cost interpreter and oral translation at all key points of contact in medical and non-medical care settings. Interpreter and oral translation services will be available to members 24 hours a day, 7 days a week. The Plan will monitor all interpreter and oral translation services provided or arranged for effectiveness. Telephone services will be available in 150 languages at a minimum.

Although the Plan had policies and procedures in place to provide interpreter services to members, the Plan did not maintain effective monitoring in the delivery of interpreter services. The Plan's Customer Call Center (CCC) phone tree system to assist monolingual, non-English-speaking and LEP members with linguistic services was not working. Upon selecting a language preference, an English-speaking representative answered the call.

During the interview, the Plan was unaware that the CCC phone tree system was not working. The Plan confirmed that there were Information Technology (IT) issues occurring with their call center system and it was not able to detect member's preferred language. "The Plan uses a process to support monolingual callers through a call "whisper". The top languages that members speak have the opportunity to select that language in the phone tree when they call member services. Following this selection, Member Services hears a "whisper" of the member's preferred language option when they connect to the member. This whisper enables the call center representative to procure an interpreter that meets the need of the caller. IT confirmed that the whisper is currently active."
Upon DHCS verifying the whisper system, the Plan continued to have IT issues with their call center system.

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The Plan's lack of effective monitoring of the linguistic services delivery will impede or delay timely access to care at all key points of contact.

RECOMMENDATIONS:

4.2.1 Improve process to monitor the delivery of interpreting services at all key points of contacts.

CATEGORY 5 – QUALITY MANAGEMENT	
5.2	**PROVIDER QUALIFICATIONS**

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
GMC/2-Plan Contract A.4.12

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
GMC/2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the

Contractor places a newly contracted provider on active status….
GMC/2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
GMC/2-Plan Contract A.4.12.B

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
GMC/2-Plan Contract A.4.12.D

Medi-Cal and Medicare Provider Status:
The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider List. Terminated providers in either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List, cannot participate in the Contractor's provider network.
GMC/2-Plan Contract A.4.12.E

SUMMARY OF FINDINGS:

5.2.1 New Provider Training

The Plan is required to conduct training for all providers within 10 working days after the Plan places a newly contracted provider on active status. (GMC/2-Plan Contract A.7.5)

Policy Number GR 106-135753: New Provider Training - Medi-Cal states Provider Relations is required to follow-up with newly contracted Medi-Cal providers within 10 days of being placed on active status to ensure receipt of a welcome-orientation packet and offer in-person training. Provider Relations Representatives will conduct on-site/in-person trainings to newly contracted providers unless waived by the provider.

Policy #COMM-102, HNCA Provider Orientation Program - Medi-Cal Managed Care states that in order to ensure practitioner and provider compliance with regulations issued by DHCS and other regulatory agencies, all newly contracting Medi-Cal providers in counties where Health Net

is the primary contractor with DHCS and who have completed the credentialing process must receive orientation materials within 10 days of being placed on active status.

The Plan's policies and procedures are not consistent with contract requirements. The Plan's policies and procedures ensure the receipt of a welcome-orientation packet within 10 days, and it allows new providers the option to waive the training. The verification study disclosed that nine providers declined the new provider training.

During the interview, the Plan stated that Provider Training was not conducted for providers who joined medical groups that had an established relationship with the Plan. However, the Plan is required to conduct training for all providers within 10 days after the Plan places a newly contracted provider on active status rather than allowing providers to opt out of the training.

The Plan is responsible for all new Provider Training. Providers may not be aware of Medi-Cal Managed Care services, policies and procedures, and methods for sharing information between the Plan, provider, Member, and other healthcare professionals. If new provider training is not provided there can be a delay in care or services to members.

RECOMMENDATIONS:

5.2.1 Revise policies and procedures to ensure that all providers receive training within ten working days of being placed on active status.

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II. COMPLIANCE AUDIT FINDINGS 2

INTRODUCTION

The audit report presents findings of the Health Net Community Solutions, Inc. (the Plan) compliance and its implementation of the State Supported Services contracts with the State of California. The State Supported Services contract covers abortion services for the Plan.

The onsite audit was conducted from May 30, 2017 through June 9, 2017. The audit covered the review period from May 1, 2016 through April 30, 2017 and consisted of review of documents supplied by the Plan.

An Exit Conference was held December 19, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit reporting findings.

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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

Policy Number LR1119-125435: Pregnancy Termination provides Medi-Cal members timely access to abortion services from any qualified contracting or non-contracting provider without prior authorization, including primary care physicians (PCP), contracted OB/GYN physicians, midwives, nurse practitioners, physician assistants, family planning clinics, and Federally Qualified Health Centers.

Medi-Cal Department Processing Guideline*:* The guideline identifies the following Current Procedural Terminology Codes (CPT) as coverage benefits: 59850-59852, 59840-59841, and 59855-59857 and Healthcare Common Procedure Coding System (HCPCS) codes A4649 with modifier codes U1 and U2, X7724, X7726, and Z0336.

Medi-Cal Evidence of Coverage informs members of their rights to access family planning services that include counseling and surgical procedures for the termination of pregnancy (abortion) from any qualified Medi-Cal Provider, including out-of-network Providers. Members under the age of 18 may access abortion services without their parent's consent.

Health Net Provider Manual informs providers that members may access most sensitive services from any qualified provider, in-or out-of-network. Sensitive services include family planning and pregnancy termination or abortion.

There were no deficiencies noted during the audit period.

RECOMMENDATIONS:

None