carelon

CARELON BEHAVIORAL HEALTH

CALIFORNIA MEDI-CAL ADDENDUM

Last updated January 2025

Any policies contained in this Provider Handbook Addendum will supersede those policies contained in Carelon Behavioral Health's National Provider Handbook. This Addendum is specific to California Medi-Cal.

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Medi-Cal Providers

The following chapters referenced below correspond with the chapters found in the Carelon National Provider Handbook. Information included under each chapter is specific to your Plan.

1. INTRODUCTION

   See Carelon National Handbook

2. ELECTRONIC RESOURCES

   See Carelon National Handbook

3. PARTICIPATING PROVIDERS

   See Carelon National Handbook

4. CREDENTIALING AND RE-CREDENTIALING

   See Carelon National Handbook

5. OFFICE PROCEDURES

   See Carelon National Handbook

6. SERVICES TO MEMBERS

   Services must be provided in a culturally competent manner and promote equitable access to all to all members, including:

   1. People with limited English proficiency or reading skills.
   2. People of ethnic, cultural, racial, or religious minorities.
   3. People with disabilities.
   4. People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
   5. People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
   6. People living in rural areas and other areas with high levels of deprivation.
   7. People otherwise adversely affected by persistent poverty or inequality

Interpreter Services

Accessing Interpreter Services and Alternative Formats

Providers may access telephonic, face-to-face, and American Sign Language (ASL) interpreting services for Carelon Behavioral Health members if they do not have their own interpreting services contract.

Telephonic Interpreting Services

Telephonic interpreting services are made available to members 24-hours a day through a Carelon Behavioral Health contracted vendor. To access telephonic interpreting services for members, please call the appropriate health plan specific phone number. Please note that the member and provider must be on the phone to provide the telephonic translation service. To utilize interpreter services for therapy sessions that are conducted face-to-face or through telehealth, please refer to the Face-to-face Interpreting Services below.

Face-to-Face or Video (telehealth) Interpreting Services

Members and providers can access free face-to-face interpreting services, including ASL. Please contact Carelon Behavioral Health to determine how to access these services. Please provide a minimum of 3 days notice. Please have the following member information ready when calling Carelon Behavioral Health:

- Provider name
- Language being requested
- Member's name and ID number
- Member's date of birth
- Requestor name and contact number
- Date, time, and duration of appointment
- Location of appointment
- Other special instructions (i.e. patient has other disabilities, driving directions, etc.)
- Video (Telehealth) if applicable
    - Platform
    - Platform Link
    - Meeting ID
    - Meeting Password
    - Providers Email Address

See Carelon National Handbook for additional information

8. MEMBER RIGHTS AND RESPONSIBILITIES

See Carelon National Handbook

9. PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES

See Carelon National Handbook

10. CLAIMS PROCEDURES

Overpayment of Claims

Providers must report to Carelon when they have received an overpayment, to return the overpayment to Carelon within 60 calendar days after the date on which the overpayment was identified, and to notify Carelon in writing of the reason for the overpayment.

Please submit the overpayment refund and a copy of the Evidence of Payment (EOP) indicating the Member ID, claim line(s), date(s) of service and the reason for overpayment.

Carelon Behavioral Health
Claims Disbursement Department
5800 Northampton Blvd.
Norfolk, VA 23502

Time Limits for Filing Claims

Carelon must receive claims for covered services within 180 days of the dates of service on outpatient claims.

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 180-day filing limit will be subject to reduction in payment or denial per Medi-Cal regulations, unless submitted as a waiver or reconsideration request, as described in this chapter. Claims received beyond 365-days will be denied for untimely filing.

How To Send a Provider Dispute to Carelon

Contracted clinician disputes submitted to Carelon must include the information listed above, for each clinician dispute. To facilitate resolution, the clinician may use either the Provider Dispute Resolution Request Form, available on our website at www.carelonbehavioralhealth.com, or a personalized form to submit the required information.

All provider disputes can be sent via email providerdisputeresolution@carelon.com or by mail to the attention of Provider Disputes at the following:

Carelon Behavioral Health
P.O. Box 1864
Hicksville, NY 11802-1864

Instructions for Filing Substantially Similar Clinical Disputes

Substantially similar multiple claims, billing or contractual disputes, should be filed in batches as a single dispute, and may be submitted using either the Clinician Dispute Resolution Request – Multiple like Claims Form or a personalized form with the required information.

Time Period for Submission of Provider Disputes

Clinician disputes must be received by Carelon within 365 calendar days from Carelon's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute or in the case of inaction, disputes must be received by Carelon within 365 calendar days after Carelon's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Clinician disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended clinician dispute that includes the missing information may be submitted to Carelon within 45 calendar days of your receipt of a returned clinician dispute.

Acknowledgment of Provider Disputes and Resolution

Carelon will provide a written acknowledgement of a dispute to the submitting provider within 15 days of receipt of the dispute if received by mail and two business days if received electronically. Carelon will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 30 calendar days after the date of receipt of the clinician dispute or the amended clinician dispute.

Past Due Payments to Clinician

If the clinician dispute or amended clinician dispute involves a claim and is determined in whole or in part in favor of the clinician, Carelon will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five calendar days of the issuance of the written determination.

Paper Submission of 180-Day Waiver Form

- Complete a 180-Day Waiver Form for each claim that includes the denied claim(s), per the instructions below
- Attach any supporting documentation
- Prepare the claim as an original submission with all required elements
- Send the form, all supporting documentation, claim and brief cover letter to:

Carelon Behavioral Health

P.O. Box 1864

Hicksville, NY 11802-1864

Completion of the 90-Day Waiver Request Form

To ensure proper resolution of your request, complete the 90-Day Waiver Request Form as accurately and legibly as possible.

1. **Provider Name**
   Enter the name of the provider who provided the service(s)
2. **Provider ID Number**
   Enter the provider ID number of the provider who provided the service(s)
3. **Member Name**
   Enter the member's name
4. **Health Member ID Number**
   Enter the plan member ID number
5. **Contact Person**
   Enter the name of the person whom Carelon should contact if there are any questions regarding this request
6. **Telephone Number**
   Enter the telephone number of the contact person
7. **Reason for Waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested
8. **Provider Signature**
   A 90-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Carelon will not accept "Signature on file".
9. **Date**
   Indicate the date that the form was signed

For Questions about claims for services that arise from a CARE Agreement or CARE plan (CARE Services) or about an enrollee that is the subject of a pending CARE petition, please contact the member's medical plan.

The CARE Act became California law on September 14, 2022, codifying Health and Safety Code section 1374.723. It created a system allowing certain people to file a petition in civil court seeking behavioral health treatment on behalf of an individual diagnosed with a schizophrenia spectrum disorder and/or a psychotic disorder and who meets other specific requirements. If the individual meets the CARE criteria, they will receive an individualized and court-ordered treatment plan (called a CARE agreement or CARE plan), which may include a requirement for the individual to receive services by county behavioral health departments (CBHDs). Beginning July 1, 2023, the CARE Act requires health plans to fully cover health care services pursuant to a CARE agreement or CARE plan without conducting utilization review.

Following is a summary of requirements:

- A health care service plan shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.
- A health care service plan may conduct a post-claim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.
- A health care service plan shall provide for reimbursement of services provided to an enrollee pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:
    - The health plan's contracted rate with the provider.
    - The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.
- A health care service plan shall provide for reimbursement of prescription drugs provided to an enrollee pursuant to this section at the health care service plan's contracted rate.
- A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

- Services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider. However, health plans may charge cost shares in accordance with an enrollee's evidence of coverage for prescription drugs associated with a CARE plan or CARE Agreement.
- A health plan shall not require claims for CARE Services to be processed in the same automated manner as standard claims and shall accept claims for CARE Services outside its standardized claims process (though health plans must reimburse claims for CARE Services timely within the claims processing timeline provided by the Knox-Keene Act).
- A health plan may not require CBHDs or providers to submit additional or different information than it requires to process claims for standard behavioral health services, though health plans may require CBHDs or providers to affirm or specify whether specific claims are for CARE Services.
- Health plans shall accept and pay claims for CARE Services that were rendered by providers qualified to provide such services under their professional license or credential in the State of California. A health plan shall not require CARE Services providers to enroll through the health plan's provider enrollment process.

10. UTILIZATION MANAGEMENT

Please call the number on the back of the member's ID card. Utilization management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and retrospective review.

Carelon's UM program is administered by licensed, experienced clinicians, who are specifically trained in utilization management techniques and in Carelon's standards and protocols. All Carelon clinicians with responsibility for making UM decisions have been made aware that:

1. All UM and CM decision making are based only on appropriateness of care and services and existence of coverage. The member's healthcare is not compromised at any time. Medical Necessity Criteria are used as a guideline.

2. There are no financial incentives to encourage adherence to utilization targets and discourage under-utilization. Financial incentives based on the number of adverse determination or denials of payment made by any individual involved in UM decision making are prohibited.

3. Carelon does not make decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual based upon the likelihood that the individual will support the denial of benefits.

4. The prohibition of financial incentives does not apply to financial incentives established between health plans and health plan providers.

5. Utilization Management staff in no way rewards or incentivizes, either financially or otherwise, practitioners, utilization reviewers, clinical care managers, physician advisers, or other individuals involved in conducting utilization/case management review, for issuing denials of coverage or service, or inappropriately restricting or diverting care including staff that engage in contract/network management activities that could potentially influence referrals to specific providers/services.

Medical Necessity

All requests for authorization are reviewed based on the information provided, according to the following definition of medical necessity:

Medically necessary services are health care and services that:

1. Are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap

2. For which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly

3. Are of a quality that meets generally accepted standards of healthcare

4. Are reasonably expected to benefit the person. This definition applies to all levels of care and all instances of Carelon's utilization review

This definition applies to all levels of care and all instances of Carelon's utilization review. In addition, for California Medi-Cal services, medical necessity is defined as reasonable and necessary to protect life; prevent significant illness or significant disability; or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as specified under Title 22 California Code of Regulations (CCR) Section 51303.

Decision and Notification Time Frames

Carelon is required by the state, federal government, NCQA, and URAC to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Carelon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

The time frames below present the internal time frames for rendering a UM determination and notifying members of such determination. All time frames begin at the time of receipt of the request. Please note: the maximum time frames may vary from those on the table below on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business.

	TYPE OF DECISION	DECISION TIME FRAME	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service Review				
Initial Registration for Other Urgent Mental Health Services	Urgent	Within 72 hours	Within 24 hours of making the decision, not to exceed 72 hours	
Initial Registration for Other Urgent Mental Health Services	Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days
Concurrent Review (includes non-inpatient treatment)				
Continued Registration for Non-Urgent Mental Health Services	Non-Urgent / Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days
Post-Service				
Registration for Mental Health Services Already Rendered	Non-Urgent / Standard	Within 30 business days	Within 30 business days	

Note: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

When the specified time frames for standard and expedited prior authorization requests expire before Carelon makes a decision, an adverse action notice will go out to the member on the date the time frame expires.

Appeal Process Detail

This section contains detailed information about the appeal process for members. The table below illustrates:

- How to initiate an appeal
- AMR information

EXPEDITED CLINICAL APPEALS	STANDARD CLINICAL APPEALS	EXTERNAL APPEALS
1. The member, or his or her authorized representative, have 90 days (or 10 days to ensure continuation of currently authorized services) from receipt of the notice of action or the intended effective date of the proposed action. The provider may act as the member's appeal representative (AMR) without completing the Designation of Appeal Representative Form. The provider can file an expedited appeal on behalf of the member regardless of the services. 2. A Carelon Physician Advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with member's attending physician. 3. Decision is made within 72 hours of initial request.	1. The members, their legal guardian, or AMR have up to 90 days to file an appeal after notification of Carelon's adverse determination. 2. A Carelon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. 3. Resolution and notification will be provided within 30 calendar days of the appeal request. 4. If the appeal requires review of medical records (post service situations), the member's or AMR's signature is required on an Authorization to Release Medical Information Form, authorizing the release of medical and treatment information relevant to the appeal.	Members have the right to file a fair hearing request with the California Department of Social Services (CDSS) upon receipt of an adverse action issued by Carelon. 1. The member may represent themselves at the fair hearing, or name someone else to be their representative. 2. Members have the right to request an expedited fair hearing if the member meets the definition of urgent care defined above. 3. The request must be filed within 90 calendar days from the date on the adverse action letter sent by Carelon. 4. If the appeal goes to state fair hearing, Carelon and Alliance representatives present the action taken and basis or reason for the action.

EXPEDITED CLINICAL APPEALS	STANDARD CLINICAL APPEALS	EXTERNAL APPEALS
4. Throughout the course of an appeal for services previously authorized by Carelon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis. **Contact Information:** Appeals requests can be made by calling Carelon's appeals coordinator at 855.765.9700.	5. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal; a resolution will be rendered based on the information available. 6. Throughout the course of an appeal for services previously authorized by Carelon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis. **Contact Information:** Appeals requests can be made by calling Carelon's appeals coordinator at 855.765.9700 or in writing to: Carelon Behavioral Health P.O. Box 1864 Hicksville, NY 11802-1864	5. The member or his/her representative then responds with the reason he/she feels the decision was not correct, and why he/she needs the type and level of service in dispute, or why Carelon should pay for a service already received. 6. The decision is made by CDSS, and the order is sent to Carelon. Carelon will comply with the final decision in the state fair hearing promptly and as expeditiously as the member's health condition requires. **Contact Information:** Members or their AMR should contact CDSS at 800.952.5253 (TDD 800.952.8349) or write to: California Department of Social Services State Hearing Division P.O. Box 944243, MS 917-37 Sacramento, CA 94244-2430

Emergency Care & 24 Hour Access to UM Staff

If a member in your care has a psychiatric emergency medical condition (as defined by Health & Safety Code section 1317.1(k) requiring a transfer for admission to a hospital psychiatric unit or acute psychiatric hospital for care or treatment necessary to relive or eliminate a psychiatric emergency medical condition, it is requested that you call the number on the back of the member's health insurance card.

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

See Carelon National Handbook