Provider Manual - Combined

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Provider Manual

The California Department of Corrections and Rehabilitation (CDCR) and Health Net Federal Services, LLC have partnered to develop and maintain a statewide network of health care providers, the Prison Health Care Provider Network (PHCPN) Project, for all CDCR adult institutions. The PHCPN provides CDCR patients access to specialty medical services in the community.

The PHCPN Operations Manual offers providers contracting through Network Providers, LLC (NPLLC) (a subsidiary of Health Net Federal Services, LLC), and participating in the PHCPN, important plan benefits, limitations and administration processes to ensure all CDCR patients receive appropriate services as needed.

The three provider types - Physicians, Hospitals, and Ancillary - are listed at the top of every page. Refer to the *Provider Type* listed at the top of the page to see if the content applies to you.

Policies and procedures listed in the PHCPN Operations Manual apply to all participating providers, unless specified otherwise in the *Provider Participation Agreement* (*PPA*).

As a participating provider, you are required to comply with applicable state laws and regulations and NPLLC policies and procedures. The contents of the PHCPN Operations Manual are supplemental to your *PPA* and its addendums. When the contents of the PHCPN Operations Manual conflict with your *PPA* , the *PPA* takes precedence.

Appeals, Grievances and Disputes

Provider Type: Physicians | Hospitals | Ancillary

Providers have 180 days from the date a claim is adjudicated to file a dispute or appeal.

Appeals Submission

Providers may submit appeals for the following reasons:

- The provider believes that the claim was not reimbursed at the contracting rate and additional payment is requested.
- The provider believes the claim, or a portion of the claim, has been denied incorrectly.

Providers may submit an appeal using the California Correctional Health Care Services (CCHCS) Appeal Request form (PDF) and submit by secure email to the California Correctional Health Care Services (CCHCS) Provider Dispute Resolution Department .

Dispute Submission

When submitting a dispute, the provider must submit the claim along with a clear explanation as to why the provider believes the request for reimbursement of an overpayment, or other action is incorrect. Submit disputes to the California Correctional Health Care Services (CCHCS) Provider Dispute Resolution Department.

The provider dispute must include:

- Provider's name.
- Provider identification (ID) number.
- Contact information, including phone number.
- Original claim number.
- Patient name and CDCR ID number.

If the dispute is regarding a request for reimbursement of an overpayment of a claim, the dispute must also include:

- Clear identification of the disputed item and clear explanation of reason for dispute.
- Date of service.
- Corrected claim, if applicable.

Claim corrections due to minor billing errors or omissions do not need to be submitted as provider disputes or appeals. Providers may submit the corrected claim to CorrectCare Integrated Health (CCIH) in the same manner as the original claim. Providers must submit corrected claims within the timely filing period and must follow Centers for Medicare and Medicaid Services (CMS) billing and coding guidelines.

Providers may **check the status of dispute** by contacting California Correctional Health Care Services - Disputes.

California Correctional Health Care Services Formulary

Provider Type: Physicians | Hospitals | Ancillary

The California Correctional Health Care Services (CCHCS) Formulary is the approved list of covered medications for patients and youth. Participating providers recommend medications for treatment based on the CCHCS Formulary.

If the patient's or youth's medical condition warrants the use of a medication not listed on the CCHCS Formulary or if there is not an acceptable medication on the formulary, participating providers must:

- Document the reason that the CCHCS Formulary medications are unacceptable.
- Consult with the referring California Department of Corrections and Rehabilitation (CDCR) primary care team[1] prior to discussing with the CDCR patient[2].
- Providers practicing onsite must also follow the CCHCS Formulary.

The CCHCS Formulary is available on the CCHCS website at cchcs.ca.gov/wp-content/uploads/sites/60/MS/CCHCS-CDCR-Formulary.pdf.

Providers prescribing non-formulary medications should follow the CCHCS non-formulary approval process.

If justification for non-formulary medication is not provided, then the formulary medication is used. Patients or youths discharged from the hospital with medications not on the CCHCS Formulary are provided a three-day supply of all non-formulary medications and active parenteral (intravenous) nutrition to assure the continuity of care during the transition back to the CCHCS Formulary.

[1] CDCR patient includes Division of Juvenile Justice (DJJ*) youth.

[2] CDCR primary care team includes the Institutional chief physician and surgeon (P&S) and/or the Institutional chief medical executive (CME).

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Claims and Provider Reimbursement

Provider Type: Physicians | Hospitals | Ancillary

Select any subject below:

Assistant Surgeon Reporting Requirement

When submitting claims for assistant surgeon services, providers must include documentation supporting the role of the assistant surgeon. If the information is not included in the operative report, providers must attach a separate report justifying the need for an assistant surgeon for the surgical procedure billed.

CMS Coding Edits and Reimbursement Changes

When the Centers for Medicare and Medicaid Services (CMS) makes any coding edits or changes to reimbursement rates, Network Providers, LLC (NPLLC) updates its systems accordingly. NPLLC implements the modifications within 90 days of receiving the changes from CMS.

The provider and NPLLC agree that, in the event such coding modifications change a payment amount in the NPLLC Prison Health Care agreement, the resulting payment amount change is effective on a prospective basis from the date the CMS change was implemented.

CMS-1500/CMS-1450 Billing Instructions

Providers must bill on the 02/12 version of the CMS-1500 claim form or its successor.

The following information must be included on every claim.

Field Type	Information Needed
CDCR Patient or DJJ* Youth Name	Enter California Department of Corrections and Rehabilitation (CDCR) patient's or Division of Juvenile Justice (DJJ*) youth's full name in box 2 on CMS-1500 or box 8 on CMS-1450
CDCR Patient or DJJ* Youth Number	Enter patient's CDCR number or DJJ* youth number in box 1A on CMS-1500 or box 60 on CMS-1450 All claims must include the patient's CDCR number or DJJ* youth number. These numbers consist of six digits for patients (one letter followed by five numbers or two letters followed by four numbers) and five digits for youth (five numbers or a combination of letters and numbers)
Institution Address	Enter institution abbreviation and address in box 5 on CMS-1500 or box 9 on CMS-1450 All claims must include only the CDCR institution abbreviation (PDF) or DJJ* facility abbreviation, city, state, and ZIP code of the institution responsible for the patient or youth on the date of service (do not list a street address)
HNET Identifier	Enter HNET in Box 26 on CMS-1500 or Box 3a on CMS-1450.
National Provider Identifier (NPI)	Enter the provider's NPI in box 24J on CMS-1500 or box 56 on CMS-1450
Tax ID Number	Enter provider's tax ID number in box 25 on CMS-1500 or box 5 on CMS-1450 Use the contracting entity's ID number. For example, if a physician provides medical services as part of participating physician group (PPG) that contracts with Network Providers, LLC (NPLLC), provide the PPG's tax ID number (TIN), not the physician's

Field Type	Information Needed
Ambulance Providers	Enter the number of miles traveled in box 24G on CMS-1500 Enter the ZIP code for the location of the point of pickup in box 23 Enter pick-up and drop-off addresses, including ZIP codes, in box 32
Telemedicine Services	Professional Services – PHCPN providers are required to use place of service (POS) code 02 in box 24B on CMS-1500. Use the appropriate HCPCS code with modifier GT in box 24D Originating Site Facility Services – Enter revenue code 780 in box 42 and HCPCS code Q3014 in box 44 on CMS-1450
Anesthesia Providers	Enter the number of anesthesia minutes, as well as start and stop times, in box 19 on CMS-1500 Show the elapsed time (minutes) in box 24G. Convert hours into minutes and enter the total minutes required for this procedure
MS-DRG Code	Enter the three-digit MS-DRG code in box 71 on CMS-1450 for all inpatient hospital claims or they may be rejected. Physician claims and outpatient hospital claims do not require this code
HCPCS/CPT Codes	Both hospital and physician claims must include all appropriate modifier codes after each HCPCS/CPT code billed
Administrative Days	Hospital providers approved to bill for administrative days must use revenue code 169 Providers who bill administrative days must attach required documentation to the claim form. When requesting reimbursement for administrative days, providers must complete and submit the Administrative Day Justification Form (PDF).

Field Type	Information Needed
Corrected Claims	Enter Corrected Claim in box 19 when submitting a corrected claim. For EDI submission, box 19 translates to Loop 2300 and segment NTE01 = ADD, then segment NTE02 = CORRECTED CLAIM

If a field is not mentioned, there is no specific format required.

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Coordination of Benefits

Coordination of benefits does not apply to patients or youths. All eligible claims are processed by California Correctional Health Care Services (CCHCS) and paid by the State Controller's Office (SCO).

Copayments and Coinsurance

Patients are not responsible for copayments, coinsurance or deductibles. Participating providers agree to accept Network Providers, LLC (NPLLC) contracting rates for services as payment in full.

CorrectCare Integrated Health

CorrectCare Integrated Health (CCIH), the third-party administrator, uses an automated payment processing system, consistent with current industry standards, to process claims. The utilization of the automated processing system reduces billing and processing errors and expedites payments. To expedite payment under the automated payment system, it is important for participating providers to adhere to the following billing requirements:

- Fill out billing forms correctly and include all required information. Incorrect or incomplete claim forms cause processing delays or rejection of claims.
- Do not mail cover sheets. The automated processing system is limited to reading standard claim forms. Cover sheets and any information on them are no longer considered.

Providers must submit all claims, using the UB-04 (CMS-1450) or CMS-1500 form, HIPAA 5010 standard 837I (institutional claim) or 837P (professional claim) transaction, to CCIH within 120 days from the date services were rendered.

With the exception of emergency care, claims must contain the prior written authorization number issued by the requesting CDCR Institution or DJJ* Facility, which coincides with the dates of services.

CCIH performs claims adjudication, which includes, at a minimum, eligibility verification, duplication validation, prior authorization validation, and NCCI/Medicare editing.

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Corrected Claims

Claims corrections due to minor billing errors or omissions do not need to be submitted as provider disputes or appeals. Providers may submit the corrected claim to CorrectCare Integrated Health (CCIH) in the same manner as the original claim. Providers must submit corrected claims within the timely filing period and follow Centers for Medicare and Medicaid Services (CMS) billing and coding guidelines.

When submitting corrected claims, providers must enter Corrected Claim in box 19 on the CMS-1500 claim form.

For EDI submission, box 19 translates to Loop 2300 and segment NTE01 = ADD, then segment NTE02 = CORRECTED CLAIM.

Electronic Claims Submission

CorrectCare Integrated Health (CCIH) contracts with Availity, LLC for the electronic data interchange (EDI) claim submission process. For successful EDI claim submission, participating providers must register with Availity. To register, providers may visit Availity's website at www.availity.com or contact Availity by phone.

Before registering, providers must review Availity's connection requirements and instructions for EDI claims submission online at www.availity.com.

Providers submitting claims electronically must follow standard Health Insurance Portability and Accountability Act (HIPAA) requirements. The following information must be included in the EDI file:

- Payer ID "CCIH" (in capital letters).
- Patient's or Division of Juvenile Justice (DJJ*) youth's full name.
- Patient's California Department of Corrections and Rehabilitation (CDCR) identification (ID) or DJJ* youth number.
- Patient relationship to Insured field must always indicate "Self".
- CDCR institution abbreviation (PDF) or DJJ* facility abbreviation, city, state, and ZIP code (do not list a street address).

To verify the patient name and CDCR ID number, access the *Inmate Locator* on the web-based tool maintained by the CDCR.

Incomplete claims, incorrectly formatted claims and claims considered ineligible during the adjudication process are rejected and returned to the provider.

Additional documentation for EDI claims

To submit additional documentation for EDI claims, use the process outlined below and a Paperwork (PWK) Fax Cover Sheet to fax the documentation to 844-836-7475.

The provider **must populate** the following PWK elements in Loop 2300 of the ASC X12 submission:

Element	Must contain	Purpose
PWK01 (Attachment Report Type Code)	A valid two-character value (e.g., "OZ" = "Support Data for Claim")	Identifies the type of documentation that will be faxed
PWK02 (Report Transmission Code)	The value "FX"	Indicates that the provider will be faxing supporting documentation associated with the claim
PWK05 (Identification Code Qualifier)	The value "AC"	Indicates that PWK06 contains an Attachment Control Number (ACN)
PWK06 (Identification Code)	A 1-50 character ACN assigned by the provider	Enables CorrectCare Integrated Health (CCIH) to match a faxed attachment with its ASC X12 837 claim

Submit supporting claim documentation with the PWK Fax Cover Sheet as follows:

- Download the PWK Fax Cover Sheet available online at the CCIH provider website at https://tpa.correctcare.com/pp_reg/portal/ca_index/, under *User Reference* .
- Complete the fax cover sheet, place it on top of the supporting documentation and fax all pages to CorrectCare Integrated Health. Note: If an attachment is required to adjudicate the associated claim, CCIH must receive it within 10 calendar days of the electronic claim's submission date; otherwise, CCIH may reject the claim.
- Attachments associated with incomplete cover sheets may be discarded.
- Use only one cover sheet for each electronic claim, regardless of the number of attachments.

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Facility Claims Submission

The following information applies only to Hospital providers.

Facility claims that span two fiscal years are not required to be split into two separate claims. Claims should be billed according to the Centers for Medicare and Medicaid Services (CMS) Medicare billing and compensation guidelines.

Medicare-Approved and Accepted Codes Without Fee Schedule Rates

There are instances when the Centers for Medicare and Medicaid Services (CMS) does not apply reimbursement rates for Medicare-accepted and approved procedure codes. Eligible complete claims billed with Medicare-approved procedure codes that do not have associated CMS rate fees, which are authorized and reimbursable, are reimbursed at a percentage of the provider's billed charges, as stated in the contract agreement.

Oral and Maxillofacial Surgeons Claim Form

The following information applies only to Physician providers.

Oral and maxillofacial surgeons should use the most current American Dental Association (ADA) Claim Form to submit claims. Providers can view a sample of the ADA Dental Claim Form or access completion instructions on the ADA website.

The ADA claim form includes several fields related to patient identification that require unique entries for California Department of Corrections and Rehabilitation (CDCR) patient and Division of Juvenile Justice (DJJ*) youth claims. Providers must enter the information in the table below for the identified fields. If a field is not mentioned, there is no specific format required.

Field Number	Field Name	Required Information
12	Policy Holder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Inmate-Patient name in Last Name, First Name format CDCR Prison Facility acronym/ abbreviation in which the inmate patient is housed along with the State, City and ZIP Code.
13	Date of Birth	Patient’s Date of Birth
14	Gender	Patient’s Gender

Field Number	Field Name	Required Information
15	Policy holder/Subscriber ID (Assigned by Plan)	CDCR patient or DJJ* youth number
16	Plan/Group Number	Leave Blank
17	Employer name	Leave Blank
18	Relationship to Policy Holder/ Subscriber	Mark" Self" as relationship to the information listed in box 12
19	Reserved for future use	Leave Blank
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	List the Inmate-Patient's name and address as entered in Box 12.
21	Date of Birth	Patient's Date of Birth
22	Gender	Patient's Gender
23	Patient ID/Account # (Assigned by dentist)	Enter the claim/Invoice number

Overpayment Procedures

If a provider is aware of receiving an overpayment, including but not limited to, overpayments caused by incorrect or duplicate payments, errors on or changes to the provider billing, the provider must promptly refund the overpayment amount to California Correctional Health Care Services (CCHCS) with a copy of the applicable Remittance Advice (RA) and a cover letter indicating why the amount is being returned. If the RA is not available, provide patient name, date of service, payment amount, provider tax ID number, and provider ID number.

When CCHCS determines that an overpayment has occurred, CCHCS notifies the provider in writing regarding the overpaid claim through a separate notice that usually includes the following information:

- Patient name and California Department of Corrections and Rehabilitation (CDCR) identification (ID) number.

- Claim identification number.
- Clear explanation of why CCHCS believes the claim was overpaid.
- The amount of overpayment.
- Copy of claim and explanation of benefits.

The provider has 30 business days to submit a written dispute to CCHCS if the provider does not believe an overpayment has occurred. In this case, CCHCS treats the claim overpayment issue as a provider dispute.

If the provider does not dispute the overpayment, the provider must reimburse CCHCS within 30 calendar days from of CCHCS notice. To reimburse CCHCS, providers must:

- Include a copy of the RA that accompanied the overpayment or the refund request letter to expedite CCHCS adjustment of the provider's account. If neither of these documents is available, the following information must be provided: patient name, date of service, payment amount, vendor name and number, provider tax ID number, provider number, claim number, invoice number, and reason for the overpayment refund.
- Make overpayment refund payable to the California Department of Corrections (CDCR) and send the overpayment refund and applicable details to CCHCS.
- If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of CCHCS, such as Performant, the provider must follow the overpayment refund instructions provided by the vendor.

Overpayment and offsets

In order to correct an overpayment, the California Correctional Health Care Services (CCHCS)/California Department of Corrections and Rehabilitation (CDCR) may offset any overpayment, incorrect payment or improper payment to a provider by withholding an amount from the next payment or several payments (as necessary) to recover the overpayment.

When an overpayment to a provider is identified, the CCHCS/CDCR will:

- Issue a written notice to the provider when an overpayment is discovered. The notice will be issued at least **30 calendar days** prior to seeking recovery. The notice will provide an explanation of the overpayment and the recovery process.
- Not offset an overpayment if there is an appeal pending. The appeal must be filed under the Dispute and Resolution process, as set forth in the provider’s contract agreement.
- If recovery of the full amount at one time imposes a financial hardship on the provider, the CCHCS/CDCR, at its sole discretion, may grant a provider’s request to repay the recoverable amount in monthly installments over a period of consecutive months, not to exceed six (6) months.

Paper Claims Submission

Providers must use correct coding and follow the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) billing and coding guidelines to ensure prompt, accurate processing of claims. Physicians should use the correct version of the CMS-1500 form and CPT and HCPCS coding, as indicated in the Provider Participation Agreement (PPA). Hospitals use the UB-04 (CMS-1450) form and current UB coding, including CPT, DRG, HCPCS, and ICD-10.

If the provider has more than one tax identification number (TIN), use the TIN under which the PPA has been signed and include the National Provider Identifier (NPI). Claims cannot be processed without these identifying numbers.

Providers must include the California Department of Corrections and Rehabilitation (CDCR) or Division of Juvenile Justice (DJJ)* identification (ID) number, and the CDCR institution abbreviation (PDF) or DJJ* facility abbreviation on each claim. Claims may be denied if the number is missing. To verify the patient name and CDCR ID number, access the *Inmate Locator* on the web-based tool maintained by the CDCR.

All claims billed for CDCR a patient or DJJ* youth must include the institution abbreviation, as well as the city, state and ZIP code of the institution responsible for the CDCR patient or DJJ* youth on the date of service. Place the abbreviation and address in box 5 on the CMS-1500 and box 9 on the CMS-1450.

Submit paper claims to CorrectCare Integrated Health (CCIH) within 120 calendar days from the date of service. Participating providers submit claims directly to CCIH. The State Controller's Office (SCO) reimburses the provider.

*Effective July 1, 2023, claims for health care services rendered to DJJ youth should be directed to the county where the patient is located. Juvenile offenders are no longer committed to DJJ. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of CDCR.

Reimbursement Amount

An explanation of payment (EOP) detailing the provider reimbursement is available on the CorrectCare Integrated Health (CCIH) website. The EOP displays amounts that were paid under the Network Provider, LLC (NPLLC) contract terms.

If coverage is denied, the claim and denial letter are mailed to the providers.

Reporting Mileage on Ambulance Claims

Providers must report mileage on ambulance claims in fractional units as follows:

- For trips less than one mile, enter 0 before the decimal, such as 0.9.
- For trips totaling up to 100 covered miles, round the total miles up to the nearest tenth of a mile and use the appropriate HCPCS code for ambulance mileage.
- For trips totaling 100 covered miles and greater, round up to the next whole number without the use of a decimal.

According to Medicare billing guidelines, ambulance providers only need to enter one service line when reporting rural or super-rural (rural areas with the lowest population density) mileage. Reimbursement for rural or super-rural mileage, which qualifies for a higher reimbursement rate, is based on the ZIP code where the patient is picked up.

The Centers for Medicare & Medicaid Services (CMS) implemented a Medically Unlikely Edit (MUE) for HCPCS code A0425 (ground mileage, per statute mile). California Correctional Health Care Services (CCHCS) requires providers to submit a trip report along with the claim when billing claims with HCPCS code A0425 for one-way trips greater than 250 miles. Claims without the trip report may result in a claims processing delay.

Telemedicine Claims Submission

Physicians and practitioners must submit professional telemedicine claims using the place of service (POS) code 02, the appropriate HCPCS procedure code for telemedicine services, and modifier GT (via interactive audio and video telecommunication systems).

Facility claims for telemedicine services must be submitted with revenue code 780 and HCPCS code Q3014.

Modifiers GT (via interactive audio and video telecommunications systems) and GQ (via an asynchronous telecommunications system) are still required when billing for telehealth services. If providers bill telehealth services with POS code 02, but without the GT or GQ modifier, there will be delays in processing the claims.

Conversely, if providers bill telehealth services with modifiers GT or GQ, but without POS code 02, there will be delays in the processing of the claim.

Therapy Billing Guidelines

Claims for outpatient rehabilitation services submitted on a UB-04 form must include appropriate revenue codes and therapy modifiers. Outpatient rehabilitation services include physical, occupational and speech therapy. Revenue codes and modifiers must be reported in the following combinations:

- Revenue code 042X (physical therapy) must be billed with modifier GP.
- Revenue code 043X (occupational therapy) must be billed with modifier GO.
- Revenue code 044X (speech therapy) must be billed with modifier GN.

Claims with revenue codes 042X, 043X and 044X without the appropriate therapy modifier are returned to the provider. Additionally, claims with more than one therapy modifier on the same service line are returned to the provider for correction.

Timely Filing Criteria

If a claim is denied for timely filing, but the provider can demonstrate good cause for the delay, CorrectCare Integrated Health (CCIH) accepts and adjudicates the claim as if it were submitted in a timely manner. California Correctional Health Care Services (CCHCS) considers and makes the determination of whether or not there is a good cause for the delay.

Submission of one of the following is usually sufficient demonstration of good cause:

- Electronic Data Interchange (EDI) confirmation that the claim was received and accepted.
- Delivery confirmation evidence (registered receipt or certified mail receipt to CCIH or CCHCS).
- Screen print from provider's accounting software to show date the claim was submitted.

Clinical Quality Management

Provider Type: Physicians | Hospitals | Ancillary

The Health Net Prison Health Care Provider Network (PHCPN) Clinical Quality Management (CQM) program monitors quality of care delivered by participating providers and manages potential quality issues (PQIs) as identified. It encompasses all medical and behavioral health providers contracting with Network Providers, LLC (NPLLC). The CQM program includes the measurement of adherence to nationally recognized clinical standards and the implementation of actions to improve quality of care. The scope of the program includes:

- Monitoring and evaluating care provided in all health care delivery settings, including behavioral health services and the behavioral aspects of health care in coordination with other medical conditions.
- Clinical quality and safety of care.
- Hospital quality comparison reports.
- Provider access and availability for patient.
- Medical record and documentation standards.
- Provider qualifications and selection.
- Monitoring continuity and coordination of care.

Health Net PHCPN has developed quality management systems that extend across the entire continuum of care. All program components are judged on their measurable effect on the patient population. The Health Net PHCPN CQM program is designed to function at the corporate and regional (statewide) level, linked by CQM committees and reporting structures.

Health Net PHCPN does not delegate its comprehensive CQM program or oversight responsibilities to participating providers, hospitals or ancillary providers. Participating providers, hospitals and ancillary providers are required to comply with the standards and requirements set forth in this operations manual and the NPLLC network contract.

Information about the Health Net PHCPN CQM program goals, processes and outcomes as they relate to patient care is available to providers on request through the PHCPN Provider Services Center.

Clinical Quality Management Committees

The Health Net Quality Improvement Committee (HNQIC) systematically manages continuous improvement of the quality of services delivered to patients. The committee evaluates input from other Health Net Quality Improvement (QI) committees to determine what QI activities are undertaken. The committee monitors and supports these activities, including implementation of meaningful, strong, system-wide interventions to improve performance when opportunities for improvement are identified. The HNQIC reports directly to the Health Net board of directors.

The following committees report to the HNQIC:

- Credentialing/Peer Review Committee.
- Specialty Network Committee.
- Clinical Quality Management (CQM) Workgroup.

Credentialing/Peer Review Committee

The Credentialing/Peer Review Committee verifies and reviews practitioners and organizational providers who contract with Network Providers, LLC (NPLLC) to render professional services to patients for training, licensure, competency, and qualifications that meet established standards for credentialing and re-credentialing. The Credentialing Committee ensures NPLLC's credentialing and re-credentialing criteria for participation in the Prison Health Care Provider Network (PHCPN) are met and maintained. The HNQIC delegates authority and responsibility for credentialing and re-credentialing peer reviews to this committee. This

committee is also responsible for peer review activities and decisions regarding clinical quality management. The committee provides a forum for instituting corrective action as necessary, and assesses the effectiveness of these interventions through systematic follow-up, for both inpatient and outpatient care.

The Credentialing/Peer Committee reports quarterly to the HNQIC and provides a quarterly summary of activities to the Health Net board of directors. Membership includes practicing medical directors or practitioners (representing primary and specialty disciplines) from each Health Net of California region (northern, central and southern California).

Specialty Committee

The Specialty Committee sets standards for the NPLLC-participating Transplantation Performance Centers and Bariatric Performance Centers, guides patients to specialty network providers, monitors performance, issues requests for corrective action plans (CAPs) and reports to HNQIC. This committee meets six times per year and reports quarterly to HNQIC.

Clinical Quality Management Committee

The Health Net PHCPN CQM committee is designed to monitor and evaluate the quality of health care on a continuous and systematic basis. The CQM committee also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety and access. The CQM committee consists of a small core of CQM staff, including a consulting physician and ad-hoc members pertinent to the report topic. At each meeting, there is focused discussion on report findings, barriers and interventions for the purpose of making and implementing decisions regarding CQM activities. This committee meets at least quarterly and reports significant findings to the Peer Review Committee when identified.

Clinical Quality Management Program

Health Net's Prison Health Care Provider Network (PHCPN) Clinical Quality Management (CQM) program is designed to monitor and evaluate the adequacy and appropriateness of health care on a continuous and systematic basis. The CQM program also supports the identification and pursuit of opportunities to improve health outcomes. The purpose and goals of the CQM program are:

- Support Health Net's PHCPN strategic business plan to promote safe quality health care and satisfy requirements for continuous clinical quality management.
- Provide an integrated structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care provided to patients.
- Establish, implement and continually evaluate the effectiveness of a written clinical quality management plan. Ensure data collection and reporting systems to provide information. Analyze hospital inpatient clinical quality measures and take action to maintain or improve clinical services to patients.
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of patient and provider information in accordance with state and federal requirements and accreditation guidelines.
- Meet the requirements of regulatory agencies and accreditation, including the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).
- Monitor clinical practices to promote outcomes for patients through improved provider relationships and through the promotion of evidence-based health care.

- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.

The Health Net PHCPN CQM program includes a written program description and an annually revised CQM work plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement Committee (HNQIC) and the Health Net board of directors approves and monitors the annual Health Net PHCPN program and the CQM work plan. The board of directors receives quarterly reports regarding Medical Affairs and Quality Management.

Clinical Quality Management Program Compliance

The Health Net Prison Health Care Provider Network (PHCPN) Clinical Quality Management (CQM) program participates in various quality improvement initiatives, including:

- The Industry Collaboration Effort (ICE), comprising CQM representatives from the major health plans in California.
- Leapfrog Group to improve patient safety through various "leaps" in health care practices and standards.
- California Cooperative Healthcare Reporting Initiative (CCHRI), a collaborative of health care purchasers, plans and providers. CCHRI sponsors a variety of data collection and quality improvement activities.
- California Quality Collaborative (CQC), a collaborative program sponsored by various health plans, California Association of Physician Groups (CAPG) and coordinated by Pacific Business Group on Health (PBGH). The program seeks to improve clinical care and service for all Californians by providing strategies at the point of care. Current CQC projects include training sessions for providers that focus on clinical performance in chronic care, enhancing the patient experience through effective physician-patient communication, and maximizing the implementation of large-scale information technology (IT) projects to benefit care. Specifically, the performance improvement curricula teach the principles of the Wagner chronic disease model; how to implement a population care registry; and leadership and change management skills. Best practices are also communicated through other provider education opportunities, such as teleconferences, meetings and other regular communications.
- The Health Net PHCPN CQM program continues its support of the California Hospital Assessment Reporting Taskforce (CHART) efforts to provide standardized hospital quality information regarding California hospitals. Through CHART, Health Net and other coalition stakeholders created a statewide process to standardize hospital performance measures. CHART's single set of measures reduces hospitals' burden of compliance while providing hospitals with clean, benchmarked, risk-adjusted data for QI purposes. Submitted data from participating hospitals represents over 80 percent of California's inpatient admissions. This data is made publicly available through a reporting tool and can be viewed through CalHospitalCompare.org or through the Health Net Hospital Comparison Report.

Participation in Public Reporting of Hospital Performance

Health Net and Network Providers, LLC (NPLLC) requires that all targeted, participating hospitals annually submit the Leapfrog Group Patient Safety Survey.

This data is reported publicly through the Hospital Comparison Report on Health Net's California Correctional Health Care Services (CCHCS) provider website through Health Net's relationship with HealthShare/WebMD. This Internet-based decision support tool enables CCHCS to receive an independent analysis of area hospitals, including their clinical outcomes, patient volume and charges for a particular procedure or medical condition. Health Net's relationship with HealthShare/WebMD brings monthly updates to its online Hospital Comparison Report so that the most current hospital quality information is available to CCHCS utilization management staff, NPLLC participating providers and Clinical Quality Management (CQM) associates.

Providers may rank the importance of a number of variables, including:

- Number of Patients - References the number of times the hospital has treated this condition or administered this therapy and, accordingly, the hospital's depth of experience.
- Mortality Rate - Indicates the number of deaths while undergoing a specific treatment. For certain conditions, the mortality rate is likely to be a key consideration.
- Complication Rate - Identifies the most common complications associated with the procedure or medical condition, and shows the complication rates for each hospital being compared.
- Average Length of Stay - Indicates how long, on average, someone is hospitalized for a certain procedure or medical condition.
- Cost - Displays the average hospital charges per procedure. Most health plans have contracts with hospitals that specify the rate the health plan pays for hospital services. While the average hospital charges may not directly impact what CCHCS must pay, hospital charges eventually have an impact on rates.

Quality of Care Issues

In compliance with regulatory requirements, Network Providers, LLC (NPLLC) monitors and evaluates potential quality issues (PQIs) involving California Correctional Health Care Services (CCHCS) patient. Providers should use the Potential Quality Issue (PQI) Referral form to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation.

The participation of the NPLLC providers in the Health Net Prison Health Care Provider Network (PHCPN) Clinical Quality Management (CQM) program is integral to success. All participating providers have agreed to provide patient data upon request and respond to queries from the Health Net PHCPN CQM program clinical staff to facilitate a quality-of-care review.

Compliance and Regulations

Provider Type: Physicians | Hospitals | Ancillary

Compliance with InterQual Guidelines

Participating providers must comply with InterQual guidelines. California Correctional Health Care Services (CCHCS) may conduct an inspection and evaluation of participating provider's offices to determine compliance with InterQual guidelines, scheduling requirements and medical treatments. CCHCS has the right not to use participating providers if they are found to be non-compliant with CCHCS requirements. CCHCS does not pay for services performed by participating providers which are deemed unacceptable.

Communicable Diseases

To protect the public from the spread of infectious, contagious and communicable disease, every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500 and 2505, are required by law to notify the local health department (LHD) and/or the California Department of Public Health. A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

Results must also be communicated to the institution Chief Executive Officer/Chief Support Executive (CEO/CSE) or Physician and Surgeon (P&S), or the Department of Juvenile Justice (DJJ)* Chief Medical Officer (CMO) within two business days, or as required by disease or condition.

The term "health care provider" includes physicians and surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, and dentists.

Notification

Reports of cases of communicable diseases must be made using the Confidential Morbidity Report.

The notification must include the following, if known:

- Name of the disease or condition being reported.
- The date of onset.
- The date of diagnosis.
- The patient name, race or ethnic group, Social Security number (SSN), age, gender, and date of birth for the case or suspected case.
- The date of death, if death has occurred.
- The name, address and phone number of the person making the report.

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

HIV Reporting Requirements for Providers

HIV is a reportable disease under California state law. Health care providers are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer within seven calendar days.

Providers must complete an HIV case report for each confirmed HIV test not previously reported and send it to the local health officer for the jurisdiction where the health care provider facility is located.

Providers must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express or registered mail or other traceable mail.
- Person-to-person transfer with the local health officer or their designee.

Providers may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV.
- A component of HIV.
- Antibodies to, or antigens of, HIV, including:
  - HIV antibody (HIV-Ab) test.
  - HIV p-24 antigen test.
  - Western (Wb) blot test.
  - Immunofluorescence antibody test.

A health care provider that orders a laboratory test used to identify HIV, a component of HIV, or antibodies to or antigens of HIV must submit to the laboratory a pre-printed laboratory requisition form that includes all documentation specified in 42 CFR 493.1105 (57 FR 7162, Feb. 28, 1992, as amended at 58 FR 5229, Jan. 19, 1993) and adopted in Business and Professions Code, Section 1220.

The person authorized to order the laboratory test must include the following when submitting information to the laboratory:

- Complete name of patient.
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year).
- Patient gender (male, female, transgender male-to-female or transgender female-to-male).
- Date biological specimen was collected.
- Name, address and phone number of the health care provider and the facility where services were rendered, if different.

Most laboratories are also required to report confirmed tests to the local health office; however, this does not relieve the provider's reporting responsibility. Laboratories may not submit reports to the local health department for confirmed HIV tests for patients at alternative testing sites other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

Tuberculosis Reporting

Tuberculosis (TB) reporting is done immediately by phone or fax to expedite the process. The Confidential Morbidity Report form should be used. When reporting a case of TB, the health care provider must provide information on the diagnostic status of the case or suspected case; bacteriological, radiological and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons; and a list of the anti-tuberculosis medications administered to the patient. In addition, a report must be made any time a patient ceases treatment for TB. Further, the local health officer may require additional reports from the health care provider.

The health care provider who treats a patient with active TB must maintain written documentation of the patient's adherence to his or her individual treatment plan. Reports to the local health officer must include the individual treatment plan, which indicates the name of the medical provider who specifically agreed to provide medical care, the address of the patient, and any other pertinent clinical or laboratory information that the local health officer may require.

In addition, each health care provider who treats a patient for active TB must examine or arrange for examination of all persons who have had contact with the patient. The health care provider must refer those contacts to the local health officer for examination, and must promptly notify the local health officer of the referral. The local health officer may impose further requirements for examinations or reporting.

Prior to discharge from an inpatient hospital, health care providers must report any cases of known or suspected TB to the local health officer and receive approval for discharge. The local health officer must review and approve the individual treatment plan prior to discharge.

Credentialing

Provider Type: Physicians | Hospitals | Ancillary

Application Process

Practitioners subject to credentialing or recredentialing and contracting directly with Network Providers, LLC (NPLLC) must submit a completed NPLLC-approved application.

Organizational providers subject to initial certification, contracting directly with Network Providers, LLC (NPLLC) must submit a completed NPLLC-approved application. An application is not required when being recertified.

By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes NPLLC to obtain information regarding the applicant's qualifications, competence or other information relevant to the credentialing review.
- Releases NPLLC and its independent contractors, agents and employees from any liability connected with the credentialing review.

Approval, Denial or Termination of Credentialing Status

The NPLLC Credentialing Committee or physician designee reviews rosters of practitioners and organizational providers meeting all NPLLC criteria and approves their admittance or continued participation in the NPLLC network.

A peer review process is used for practitioners with a history of adverse actions, complaints, negative quality improvement (QI) activities, impaired health, substance abuse, health care fraud and abuse, criminal history, or

similar conditions to determine whether a practitioner should be admitted or retained as a participant in NPLLC network.

Practitioners are notified of all decisions regarding approval, denial, limitation, suspension, or termination of credentialing status consistent with health plan, state and federal regulatory requirements and accrediting entity standards. All initial credentialing files are processed within 90 days of receipt of a complete application. This notice includes information regarding the reason for denial determination. If the denial or termination is based on health status, quality of care or disciplinary action, the practitioner is afforded applicable appeal rights.

Practitioners who fail to respond to recredentialing requests may be subject to administrative termination from the NPLLC network.

Practitioners who have been administratively denied are eligible to reapply for network participation as soon as the administrative matter is resolved.

Practitioners are notified of the Credentialing Committee decision within 60 calendar days of the decision.

California Correctional Health Care Services Onsite Credentialing Requirements

The following information applies only to Physician providers.

Prison Health Care Provider Network (PHCPN) participating providers who would like to deliver services onsite at a California Department of Corrections and Rehabilitation (CDCR) institution must complete California Correctional Health Care Services (CCHCS) credentialing requirements in addition to the Network Providers, LLC (NPLLC) credentialing process. Providers must submit a completed credentialing application via the State's Electronic Credentialing Tool (MD-App) and receive approval from the CCHCS Credentialing and Privileging Support Unit (CPSU) before beginning onsite services.

Participating providers can view and print CCHCS credentialing requirements from the CDCR website. Providers can also contact the CDCR by email or phone to request credentialing applications.

MD-App Authorization and Consent form are only accepted from PHCPN providers that have completed and satisfied NPLLC credentialing requirements. Providers submit the completed MD-App Authorization and Consent form to NPLLC. NPLLC submits the MD-App request to CCHCS on behalf of providers. NPLLC will notify the provider via email of CPSU's credentialing decision.

Network Providers, LLC Standards of Participation

All practitioners participating in the Network Providers, LLC (NPLLC) network must comply with the following NPLLC standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing and practitioners due for recredentialing must complete all items on an approved credentialing application and supply supporting documentation, if required. The verification time limit for a NPLLC approved application is 180 days. Prospective providers must submit a completed application based on the application developed by the Council for Affordable Quality Healthcare (CAQH) that complies with federal and state regulatory requirements and NCQA standards. Applications can be accessed on the CAQH website at www.caqh.org via the Universal Provider DataSource link. Supporting documentation includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable.
- Continuous work history for the previous five years with a written explanation of any gaps of a prescribed time frame (initial credentialing only).
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one NPLLC participating hospital or surgery center, or a documented coverage arrangement with a NPLLC credentialed, participating practitioner of a like specialty.
- Professional/medical specialty information.
- Malpractice insurance coverage that meets NPLLC standards.
- Answers to all confidential questions and explanations provided in writing for any questions answered adversely.

Investigations

NPLLC investigates adverse activities indicated in a practitioner or provider's initial credentialing or recredentialing application materials or identified between credentialing cycles. NPLLC may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. NPLLC may require a practitioner or provider to supply additional information regarding any such adverse activities. Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board.
- Current or past chemical dependency or substance abuse.
- Health care fraud or abuse.
- Complaints.
- Substantiated quality of care concerns activities.
- Impaired health.
- Criminal history.
- Office of Inspector General (OIG) Medicare/Medicaid sanctions.
- Federal Employees Health Benefits Program (FEHBP) debarment.
- Substantiated media events.
- Trended data.

At NPLLC's request, a practitioner or provider must assist NPLLC in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within the prescribed time frames.

Organizational Providers

An organizational provider (OP) is an institutional provider of health care that is licensed by the state or otherwise authorized to operate as a health care facility. Examples of OPs include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and ambulatory surgical centers (ASCs).

OPs that require certification and recertification by Network Providers, LLC (NPLLC) or its delegated entities include:

- Hospitals.
- Free-standing and ASCs, including abortion clinics.
- Dialysis/end-stage renal disease (ESRD) care providers.

- Laboratories.
- Office-based surgery suites.
- Comprehensive outpatient rehabilitation facilities.
- Physical therapy.
- Portable X-ray suppliers.
- Radiology/imaging centers.
- Behavioral health facilities (inpatient, residential and ambulatory).
- Urgent care centers.
- Federally qualified health centers and rural health clinics.
- Other providers as deemed necessary.

Providers contracting directly with NPLLC must submit a completed, signed NPLLC approved hospital or ancillary facility credentialing application for initial inclusion into our network and any supporting documentation to NPLLC for processing. The documentation, at a minimum, includes:

- Evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an on-site survey prior to being issued a state license. Accepted agency surveys include those performed by the state Department of Health and Human Services (DHHS), Department of Public Health (DPH) or Centers for Medicare and Medicaid Services (CMS).
- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess a current city license, fictitious name permit, certificate of need, or business registration.
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent DHHS/DPH site survey as described above is required. A favorable site review consists of compliance with quality of care standards established by CMS or the applicable state health department. NPLLC obtains a copy of each surgery center's site survey report and ensures each provider has received a favorable rating. This may include a completed corrective action plan (CAP) and DHHS CAP acceptance letter.
- Professional and general liability insurance coverage that meets NPLLC requirements.
- Overview of the facility's quality assurance/quality improvement program upon request.

Organizational providers are recertified at least every 36 months to ensure each entity has continued to maintain prescribed eligibility requirements.

Practitioner's Rights

Right to Review/Request for Current Network Status

A practitioner has the right to review information obtained by Network Providers, LLC (NPLLC) for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (such as, malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to NPLLC's credentialing manager or supervisor. The manager or supervisor of credentialing notifies the practitioner within 72 hours of the date and time when such information is available for review at NPLLC's Credentialing Department. Upon written request, the NPLLC Credentialing Department provides details of the practitioner's current status in the initial credentialing or recredentialing process.

Notification of Discrepancy

Practitioners are notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his or her application. Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

A practitioner who believes that erroneous information has been supplied to NPLLC by primary sources may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed explanation, to NPLLC's Credentialing Department manager or supervisor. Notification to NPLLC must occur within 48 hours of NPLLC's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his or her credentials file. Upon receipt of notification from the practitioner, NPLLC re-verifies the primary source information in dispute. If the primary source information has changed, a correction is made immediately to the practitioner's credentials file. The practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to NPLLC's Credentialing Department via letter or fax within 10 business days. The Credentialing Department re-verifies primary source information if such documentation is provided. If after 10 business days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.

Primary Source Verification for Credentialing and Recredentialing

The Network Providers, LLC (NPLLC) Credentialing Department obtains and reviews information on a credentialing or re-credentialing application and verifies the information in accordance with the NPLLC primary source verification practices. NPLLC requires participating physician groups (PPGs) to which credentialing has been delegated to obtain primary source verification* in accordance with NPLLC standards of participation, state and federal regulatory requirements and accrediting entity standards.

*Primary Source Verification

- Audiologist.
- Dentist and dental hygienist.

- Doctor of medicine.
- Doctor of osteopathy.
- Doctor of podiatric medicine.
- Licensed clinical social worker.
- Optometrist.
- Oral and maxillofacial surgeon.
- Physician assistant.
- Physical therapist and occupational therapist.
- Psychologist.
- Registered nurse anesthetist, nurse practitioner and certified nurse midwife.

Organizational Providers

- Behavioral health facilities (inpatient, residential and ambulatory).
- Comprehensive outpatient rehabilitation facilities.
- Dialysis and end-stage renal disease care providers.
- Federally qualified health centers/rural health clinics.
- Freestanding and ambulatory surgery centers.
- Hospitals.
- Laboratories.
- Physical therapy.
- Portable X-ray suppliers.
- Radiology and imaging centers.
- Urgent care centers.

Recredentialing of Practitioners

The Network Providers, LLC (NPLLC) credentialing program establishes criteria for evaluating continuing NPLLC participating practitioners. This evaluation, which includes applicable primary source verifications, is conducted in accordance with health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners meeting and maintaining NPLLC standards for participation requirements are retained in the NPLLC network.

Practitioners due for recredentialing must complete all items on an approved NPLLC application and supply supporting documentation, if required. Documentation includes, but is not limited to:

- Current state medical license.
- Attestation to the ability to provide care to NPLLC patients without restriction.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate or Chemical Dependency Services (CDS) certificate, if applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state.
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one NPLLC participating hospital or surgery center, or a documented coverage arrangement with a NPLLC credentialed or participating practitioner of a like specialty.
- Malpractice insurance coverage that meets NPLLC standards.
- Trended assessment of practitioner's complaints, quality of care and performance indicators.

Terminated Contracts and Reassignment of Patients

Network Providers, LLC (NPLLC) notifies California Correctional Health Care Services (CCHCS) as required under state law if a practitioner's contract participation status is terminated. NPLLC oversees reassignment of patients to another participating provider where appropriate.

Emergency Services

Provider Type: Physicians | Hospitals | Ancillary

Emergency services are defined as the immediate care or treatment necessary to prevent death, severe or permanent disability or to alleviate severe pain, including medically necessary crisis intervention for patients or Division of Juvenile Justice (DJJ)* youths suffering from situational crisis or acute episodes of mental illness, in accordance with CCR, Title 15. Emergency services are available 24 hours a day.

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Hospital Services

Provider Type: Physicians | Hospitals | Ancillary

Hospitals must make language interpretation available to California Department of Corrections and Rehabilitation (CDCR) patients, medical parolees and Department of Juvenile Justice (DJJ)* youths for inpatient, outpatient and emergency care services.

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Medical Parolees

Provider Type: Physicians | Hospitals | Ancillary

A medical parolee is defined as a person released from confinement pursuant to California Penal Code 3550.

In addition to the medical services provided for patients incarcerated in California Department of Corrections and Rehabilitation (CDCR) institutions, providers may care for medical parolees, who upon parole are typically placed in skilled nursing facilities (SNFs) located in counties near their county of residence prior to incarceration. The following are provider requirements for providing services to medical parolees:

- Providers must acknowledge CDCR's statutory authority as custodial guardian for medical parolees.
- Providers must also acknowledge that the custody aspects of medical parolees' care is regulated by the medical parolee's assigned parole agent.
- Providers must promptly notify the assigned parole agent of any critical events with regard to the medical parolee. Critical events include, but are not limited to, the following:
    - Any change in the medical parolee's location.
    - Any criminal activity on the part of the medical parolee.
    - Any other significant event or circumstances related to the medical parolee that would be of reasonable interest to the parole agent.
- In the absence of the parole agent, the provider must contact the unit supervisor of the parole unit to which the medical parolee is assigned.
- Medical parolees remain the financial responsibility of CDCR.

Claim Submission

Providers must submit claims for medical parolees to CorrectCare Integrated Health (CCIH).

Medical Records

Provider Type: Physicians | Hospitals | Ancillary

Participating providers are required to maintain patient medical records in a manner that is current, detailed, complete, and organized. In addition, medical records must reflect all aspects of patient care, be readily available to health care providers and provide data for statistical and quality-of-care analysis.

Standards for the administration of medical records by participating providers are established by Network Providers, LLC (NPLLC). The standards form the basis for the evaluation of medical records by NPLLC.

NPLLC requires that participating providers have a written policy in place that keeps protected health information (PHI) confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism

designed to safeguard medical records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about patient information to maintain confidentiality.

Provision of Medical Records

Participating providers are required to provide NPLLC with copies of medical records and accounting and administrative books and records, as they pertain to the *Provider Participation Agreement (PPA)* .

The participating provider has financial responsibility to provide copies of medical records so that NPLLC can provide clinical quality management.

Medical records may be required for regulatory reviews by the Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and Independent Quality Review and Improvement Organization (QIO).

Confidentiality of Medical Records

Patients are entitled to confidential treatment of patient communications and records. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Written authorization from the patient or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the patients care, except as permitted or as necessary for administration by Network Providers, LLC (NPLLC).

NPLLC requires that participating providers have a written policy in place that keeps protected health information (PHI) confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about patient information to maintain confidentiality.

PHI is considered confidential and encompasses any individual health information, including demographic information collected from a patient, which (1) is created or received by NPLLC and relates to the past, present or future physical, mental health or condition of a patient; the provision of health care to a patient; or the past, present or future payment for the provision of health care to a patient, and (2) that identifies the patient or there is a reasonable basis to believe the information may be used to identify the patient. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written patient authorization.

Agencies Must be Authorized to Receive Medical Records

The relationship and communication between a participating provider and patient is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and PHI, whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

Basic Principles

PHI may be shared with participating providers in the same facility only, on a need-to-know basis, and may be disclosed outside the facility only to the extent necessary such release is authorized.

In accordance with HIPAA, PHI, whether it is written, oral or electronic, is protected at all times and in all settings. Disclosure of PHI must have prior written patient authorization. NPLLC participating providers only release PHI without authorization when:

- Needed for payment.
- Necessary for treatment or coordination of care.
- Used for health care operations (including, but not limited to, clinical quality management).
- Where permitted or required by law.

Participating providers may transmit PHI to individuals or organizations who contract to provide covered services to patient. PHI cannot be intentionally shared, sold or otherwise used by NPLLC its subsidiaries, participating providers, or affiliates for any purpose other than for payment, treatment or health care operations or where permitted or required by law without an authorization from the patient.

Medical Record Documentation

Network Providers, LLC (NPLLC) developed standards for the administration and evaluation of medical records. Participating providers are required to comply with all medical record documentation standards.

NPLLC requires participating providers to maintain medical records in a manner that is current, detailed, complete, organized, and permits effective and confidential member care and quality review. Medical records must reflect all aspects of patient care, be readily available to health care providers and provide data for statistical and quality-of-care analysis.

Medical Records Documentation Standards

Participating providers are required to meet NPLLC medical record documentation standards. The following documentation guidelines must be followed and all of the elements must be included in the medical records of patients.

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing-impaired persons, individual personal biographical information, emergency contact, and identification of the patient's assigned primary care physician (PCP).
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the offering of advance health care directive information and education to patients ages 18 and older must be included.
- Coordination of care - Notation of missed appointments, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans.
- Preventive care:
    - Adult preventive care - Notation of periodic health evaluations according to the United States Preventive Services Task Force (USPSTF); assessment of immunization status and the year of the immunization(s); tuberculosis screenings and testing; blood pressure and cholesterol screenings; Chlamydia screenings for sexually active females to up to age 25 or at risk; and mammograms and Pap smears for females.

- Perinatal preventive care - Notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, domestic violence and abuse screenings; HIV, alpha fetoprotein (AFP) and genetic screenings.

Medical Record Performance Measurements

Network Providers, LLC (NPLLC) monitors medical record documentation through a variety of measures, which includes, but is not limited to, various quality initiatives, data collection by way of medical record audits. Data is aggregated and analyzed at least annually. Opportunities for improvement are identified and appropriate interventions are implemented based on compliance levels established for each individual activity. Interventions may include sending provider updates, educational or reference materials, creating template medical record forms, and provider and staff education and training. Participating providers are required to obtain a performance level of 80 percent on the medical record performance measures.

Procedure

Participating providers' policies and procedures governing the confidentiality of medical records and the release of protected health information (PHI) must address levels of security of medical records, including:

- Assurance that the files are secure and not accessible to unauthorized users.
- Indication of who has access to the medical records.
- Identification of who may execute different database functions for computerized medical records.
- Assurance that staff is trained with respect to the Health Insurance Portability and Accountability Act (HIPAA), privacy requirements and related policies.
- Signed confidentiality agreements on file from staff who have access to medical records.
- Assurance that photocopies or printouts of the medical records are subject to the same control as the original record.
- Designation of a person to destroy the medical record when required.

Release of medical information guidelines must address:

- Requests for PHI via the phone.
- Demands made by subpoena duces tecum.
- Timely transfer of medical records to ensure continuity of care when a patient is referred to a new provider or California Department of Corrections (CDCR) institution.
- Availability and accessibility of patient medical records to Network Providers, LLC (NPLLC) and to California Correctional Health Care Services (CCHCS) and CDCR or their delegates involved in assessing quality of care.
- Requirements for medical record information between providers of care:

- A physician or licensed behavioral health care provider making a patient referral must transmit necessary medical record information to the provider receiving the patient referral.
- A physician or licensed behavioral health care provider furnishing a referral service provides appropriate information back to the referring provider.
- A physician or licensed behavioral health care provider requesting information from another treating provider as necessary to provide care.

An authorization form for release of information not covered by HIPAA must be in plain language and must contain the following to be HIPAA compliant:

- A specific and meaningful description of the information to be used or disclosed.
- The name of the person or entity authorized to make the requested use or disclosure.
- The name of a person or entity to which the use or disclosure may be made.
- A description of each purpose or use for the information. If the individual requests the authorization for his or her own purposes, the description here may read simply "at the request of the individual".
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.
- The signature of the individual and the date.
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided.
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation.
- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization unless a valid exception applies (such as, pre-enrollment underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception.
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization.
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule.

Provider Responsibilities and Procedures

Participating providers must establish procedures ensuring that any advance directive is brought to the attending provider's immediate attention if, in the opinion of that provider, the patient is unable to make health care decisions. If any patient has such a directive in place, the following must occur:

- Each health care provider must honor advance directives to the fullest extent permitted under California and federal law.

- Participating providers must be open to any discussion with a patient and provide medical advice if the patient desires guidance or assistance regarding this matter.
- In no event may the participating provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an advance directive.

Written Protocols

Participating providers are required to have systems and procedures in place that provide consistent, confidential and comprehensive record-keeping practices. Written procedures must be available upon request by Network Providers, LLC (NPLLC) for the following:

- Confidentiality of patient information policy and procedure, which address keeping protected health information (PHI) of the patient confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included.
- Release of medical records and information, including faxes.
- Medical record organization standards policy and procedure, which include information about individual medical records; securely fastened medical records; medical records with patient identification on each individual page; and a consistent area in the medical record designated for the patient's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, as well as discharge summaries.
- Filing system for records (electronic or hardcopy).
- Formal system for the availability and retrieval of medical records policy and procedure, which must allow for the ease of accessibility to medical records for scheduled patient encounters within the facility or in an approved health record storage facility off the facility premises.
- Filing of partial medical records policy and procedure, which must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record.
- Retention of medical records in accordance with state laws and regulations.
- Preventive care guidelines for patient.
- Referrals to specialists.
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner.
- Inactive medical records policy and procedure, which must include guidelines that describe how and when a medical record becomes inactive. Patient medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records must do so in a manner that preserves the confidentiality of patient information.

Off-Site Medical Imaging Facilities

Provider Type: Physicians | Hospitals | Ancillary

Off-site medical imaging facility providers must:

- Provide community standard medical technology equipment, staff and professional collaboration with California Correctional Health Care Services (CCHCS) medical providers.
- Include technical and professional component as designated for general diagnostic procedures and any other radiology services.
- Have a user interface consistent with California Department of Corrections and Rehabilitation (CDCR) radio information system/picture archiving and communication system (RIS/PACS), which provides accepting exam requests via an interface, ability to send digital images and related information (such as screening and consent forms, and lab values) via digital imaging and communications in medicine (DICOM^{SM}) to the CDCR RIS/PACS system upon completion of exams.
- In the event an interface is not provided, providers must send the CDCR medical imaging center CDs of all medical imaging procedures performed and exam reports on CDCR patients. The CDs must be sent no later than three days after the date of exam via mail to the CCHCS Imaging Records Center
- Provide remote access to the medical facility's RIS/PACS to allow printing of reports and exams.
- Providers who perform imaging services must issue a final, signed interpretive report within two business days. Providers who fail to provide documentation by the stated time frame may be subject to delay in payment or denial, until documentation is received.

Off-site Radiology Services

Provider Type: Physicians | Hospitals | Ancillary

Off-site radiologists are required to:

- Provide documentation of certification, continuing medical education (CME) or qualifications when requested by designated California Correctional Health Care Services (CCHCS), Department of Juvenile Justice (DJJ)* staff or Network Providers, LLC (NPLLC).
- Have the ability to fax, electronically transmit or email (encrypted) an interpretive report to the requesting California Department of Corrections and Rehabilitation (CDCR) institution's radiology department and the imaging records center upon approval of the interpreting radiologist within two business days of receipt of exam, Monday through Friday. Reports must also be available via a portal provided by the radiology group for other CCHCS off-site/on-site medical providers to review exam results within two business days of approval of the interpreting radiologist Monday through Friday.

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youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

On-Site and Mobile Medical Imaging

Provider Type: Physicians | Hospitals | Ancillary

All medical imaging staff must have appropriate licensing in each modality they perform, including intravenous (IV) certification and fluoroscopy licenses, and provide a copy to California Correctional Health Care Services (CCHCS) to meet regulatory requirements.

On-Site Specialty Care Providers

Provider Type: Physicians | Hospitals | Ancillary

On-site specialty care providers at the California Department of Corrections and Rehabilitation (CDCR) or Department of Juvenile Justice (DJJ)* facility are responsible for:

- Reviewing the Health Care Contractor's On-Site Orientation handbook and providing a signed self-certification form to Network Providers, LLC (NPLLC) prior to the commencement of services. The handbook and self-certification form are located on the California Correctional Health Care Services (CCHCS) website. Once signed, it can apply to all institutions at which the provider renders care.
- If CCHCS revises the handbook, the network is notified and all on-site providers are responsible for reviewing the revised version of the handbook. They must then sign and submit a new self-certification form to NPLLC.

Network onsite providers may not dispense durable medical equipment to CDCR patients.

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Pathology Services

Provider Type: Physicians | Hospitals | Ancillary

The following are the requirements for pathology services:

- Pathology services must be performed by qualified pathologists in accordance with federal standards in anatomic pathology and licensed in the state in which they provide care.
- Pathology services must provide reports of external quality assurance programs quarterly.
- A "wet read" of a preliminary cancer, melanoma and significant diagnosis should be provided to the ordering clinicians within 24 hours of receiving the specimens at the testing institutions.
- Consultations regarding the medical significance of the laboratory results or data provided.
- Mandatory second pathologist review when indicated by current standard of care (such as any malignancy, high-grade dysplasia in Barrett's, any dysplasia in IBD, and others).
- Retrospective review of two percent of all cases, randomly selected, or selected by organ system for systemic review.
- Mandatory review of any outside pathology materials upon which a definitive therapy is planned within a referral institution.
- Pathology department must utilize a specific set of preferred consultants who are recognized experts within each subspecialty.
- All gross specimens must be retained until at least two weeks after the final reports are signed and results reported to the referring physician.
- Intradepartmental consultations must be included in the patient's final report, or filed separately.
- The results of surgical consultations must be documented and signed by the pathologist who made the diagnosis.
- Statistical reports on turnaround time are required for the following categories of pathology specimens:
    - Routine, such as Pap smears.
    - Advanced, such as molecular pathology, flow cytometry and fluorescence in situ hybridization (FISH).

Prior Authorization

Provider Type: Physicians | Hospitals | Ancillary

The California Department of Corrections and Rehabilitation (CDCR) or the Department of Juvenile Justice (DJJ)* must provide written prior authorization for medically necessary services before a CDCR patient or DJJ* youth receives services. The prior authorization must be included in the CDCR patient or DJJ* youth’s treatment package provided at the time of treatment.

Medically necessary services are supported by outcomes data as effective medical care, and in accordance with Title 15 CCR, Division 3, Chapter 2, Article 1, § 3999.98. “Medically Necessary" means health care services that are determined by the attending or primary medical, mental health, or dental care provider(s) to be needed to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data or clinical evidence as being an effective health care service for the purpose intended or, in the absence of available health outcome data, is judged to be necessary, and is supported by diagnostic information or specialty consultation.

On the day of the scheduled appointment, patients arrive with a treatment package. The treatment package is in the possession of the escorting correctional officer and contains the Health Care Services Physician Request for Services form. Participating providers must provide only those services listed on the form. They may not order additional tests, specialty services or make direct referrals.

If the participating provider believes additional medically necessary services are required, he or she must obtain written authorization from the headquarter (HQ) UM Regional Physician Advisor or Nursing Consultant Program Review (NCPR UM) case manager before performing any further non-emergency services. In these instances, an email address will be sent to the provider with instructions on the process. The written authorization for treatment will be communicated via CCHCS HQ UM Regional Physician Advisor by email within 24 hours of the request. These services include, but are not limited to:

- Non-emergency specialty treatment.
- Consultations by specialty physicians.
- Diagnostic procedures not specifically stated in the CCHCS Request for Services form.
- Any excluded services specifically listed in California Code of Regulation (CCR), Title 15, Division 3, Chapter 1, Subchapter 4, Article 8, Section 3350.1.

Providers send evaluations and recommendations back to the CDCR institution in the treatment package. The primary care provider for the institution reviews the evaluation and recommendations and authorizes additional services, as appropriate. Participating providers must not discuss the course of treatment or requests for additional services with the patient.

Participating providers are not reimbursed for services that are performed without prior authorization from CCHCS.

Participating hospitals must not transfer CDCR patients or DJJ* youth to other facilities without prior written authorization from the CDCR institution's CEO, CME, or DJJ* FCMO or their designee unless there is a documented and verified need for emergency services that cannot be performed at the current facility.

Notification about emergent care

Hospital emergency rooms do not need to seek authorization prior to performing emergency evaluation and stabilization of the patient. Providers must notify CCHCS HQ UM Regional Physician Advisor via their email address to request approval authorization for additional treatment or services.

Notification to providers about changes

If CDCR/CCHCS adopts another objective standard for UM review to screen CDCR patients[1] regarding prior authorization, inpatient admissions, and other types of UM review, the Deputy Medical Executive (DME) for UM must notify the provider or other parties of the new standards no less than 30 calendar days before the new standard is implemented.

[1]CDCR patient includes DJJ youth.

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Provider Oversight

Provider Type: Physicians | Hospitals | Ancillary

Select any subject below:

Continuity of Care

To ensure continuity of care within the California Department of Corrections and Rehabilitation (CDCR) institution, providers must furnish all clinical documentation to California Correctional Health Care Services (CCHCS) within 48 hours of a patient office visit. Clinical documentation includes, but is not limited to prescriptions, clinical notes, discharge summaries, and brief operative notes.

Facility Access for the Disabled

Network Providers, LLC (NPLLC) and its participating providers do not discriminate against CDCR patients who have physical disabilities. Participating providers are required to provide reasonable access for disabled patients in accordance with the Americans with Disabilities Act of 1990 (ADA).

Facility and Physician Additions and Deletions

Participating providers and hospitals must notify Network Providers, LLC (NPLLC) in writing at least 90 days prior to terminating their relationship with NPLLC (or as stated in their *Provider Participation Agreement (PPA)*). NPLLC offers transition of care assistance to patients who request to complete a course of treatment of covered services by a terminated provider.

Interpreter Services Requirements

The California Department of Corrections and Rehabilitation (CDCR) notifies participating providers of CDCR patients' or Division of Juvenile Justice (DJJ)* youths' primary language, primary method of communication and interpreter service requirements when appointments are scheduled. At the time the appointment is scheduled, providers must inform CDCR if required interpreter services cannot be provided. If interpreter services are not available, California Correctional Health Care Services (CCHCS) provides an interpreter at no cost to the provider.

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Patient or DJJ Youth Death

Participating providers must immediately notify the institution chief executive officer/chief medical executive/ chief medical officer (CEO/CME/CMO) or designee in the event of a CDCR patient, Parole Agent or UM team for a medical parolee, or facility chief medical officer (FCMO) for a Department of Juvenile Justice (DJJ)* youth death while under their care or in the hospital. The attending provider(s) will discuss with the Institution CEO/ CME or designee and/or the DJJ* FCMO, or their designee the appropriateness/need for a post-mortem. Both parties shall mutually agree upon the decision for an autopsy, prior to or in conjunction with the coroner's office. The coroner's office has the final decision on whether an autopsy is necessary.

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Written Discharge Summary or Transfer Summary

Providers performing hospital services must issue a written discharge summary and/or transfer summary, upon hospital discharge of a patient back to the appropriate California Department of Corrections and Rehabilitation (CDCR) institution, a medical parolee back to the appropriate skilled nursing facility or a Department of Juvenile Justice (DJJ)* youth back to the appropriate DJJ* facility. Providers must give the CDCR institution's health care manager (HCM), chief executive officer (CEO), chief medical executive (CME), or representative and/or the DJJ* facility chief medical officer (FCMO), or their designee, a full, dictated or written formal discharge summary within three days of the discharge of a patient in all cases. The discharge summary and/or transfer summary must include the staff physician's recommendations for continuance of care for the patient. The discharge or transfer summary precedes or accompanies the CDCR patient1 when discharged. The discharge and transfer summary must be signed by a physician and include the following essential information:

- Diagnosis
- Medications
- Wound care
- Known allergies
- Lab tests ordered
- Imaging studies ordered
- Treatments
- Dietary requirements
- Needed follow-up appointments
- Rehabilitation potential
- Referrals for additional care
- Recommended activities

California Correctional Health Care Services (CCHCS) may request hospital providers to use a standardized discharge summary form, created by CCHCS. In the event labs or other test results are pending when discharge summaries are issued, providers must provide an updated report within 24 hours of receipt for labs or test results. Upon request, network hospitals must grant CCHCS clinical staff access to hospital medical records systems, if feasible.

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For additional information, select any subject below:

Provider Oversight | Access to Care and Availability Standards

Provider Type: Hospitals

Availability of Providers

Provider Delays

On the day of a scheduled appointment, if there is a delay that prevents services from being delivered, providers or their staff must immediately notify:

- The chief medical executive (CME), or their designee, at the California Department of Corrections and Rehabilitation (CDCR) facility and the facility chief medical officer (FCMO) by phone, if the patient or Department of Juvenile Justice (DJJ)* youth is still at the facility.
- The custody officers, and provide an estimate of the delay, if the patient or DJJ* youth is already at the provider's office.

If providers are unable to render scheduled services for reasons other than illness of their staff members, providers must notify California Correctional Health Care Services (CCHCS) at least 24 hours in advance or immediately provide alternative medical service arrangements to avoid disruption of service.

CCHCS may cancel, modify or change a request for services by phone without incurring any liability, up to 24 hours before services are provided. If CCHCS cancels, modifies or changes a request for any reason, including emergency security situations, such as a lockdown, less than 24 hours before a scheduled service CCHCS makes every effort to notify the provider immediately.

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Appointment Visits and Wait Times

Appointment Access Standards for CDCR Patient and Division of Juvenile Justice (DJJ) Youth

The time a patient or DJJ* youth waits for a scheduled office visit must not exceed 30 minutes past scheduled appointment time.

Routine appointments for specialist services must not exceed a 90 calendar day period upon request for an appointment from California Correctional Health Care Services (CCHCS). Outpatient specialty care must also be scheduled within 90 calendar days of receiving the request from CCHCS or DJJ* for elective services.

Appointments for medium priority specialty care must not exceed a 45 calendar day period from the CCHCS appointment request.

Appointments for urgent care must not exceed 14 calendar days following CCHCS or DJJ* appointment request.

There must be access to a restroom and water fountain in waiting areas for block-scheduled appointments.

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Scheduling Blocks

Providers must make every effort to offer scheduling blocks to treat multiple patients consecutively to minimize travel and custody costs.

Block-scheduled appointments for multiple California Department of Corrections (CDCR) patients or Department of Juvenile Justice (DJJ)* youths during the same day must start and finish with no more than a 10-minute wait time between each appointment.

There must be access to a restroom and water fountain in waiting areas for block-scheduled appointments.

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Notification of Illness or Death

Participating providers must immediately notify the institution chief executive officer/chief medical executive/ chief medical officer (CEO/CME/CMO) or designee in the event of a CDCR patient, parole agent or UM team for a medical parolee, or facility chief medical officer (FCMO) of a DJJ* youth death while under their care or in

the hospital. The attending provider(s) will discuss with the Institution CEO/CME/CMO or designee and/or the DJJ* FCMO, or their designee the appropriateness and need for a post-mortem. Both parties must mutually agree upon the decision for an autopsy, prior to or in conjunction with the coroner's office. The coroner's office has the final decision on whether an autopsy is necessary.

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Provider Oversight | Psychiatric Provider Responsibilities

Provider Type: Hospitals

Acute Psychiatric Hospital Admissions

The Division of Juvenile Justice (DJJ)* provides pertinent clinical information on DJJ* youths referred to an acute psychiatric hospital for admission. DJJ* faxes the referral packet, which includes the Referral to Inpatient Psychiatric Programs (PDF) and Inpatient Medical Screening (PDF) forms. Pertinent clinical information includes, but is not limited to:

- Principal psychiatric diagnosis.
- Recent and past history of aggressive or self-abusive behavior.
- Existing medical conditions, including alerts for contagious diseases.
- Current medications.
- Dietary restrictions.

In the case of emergency admissions, where some pertinent clinical information is not prepared or available, DJJ* provides the information as soon as possible.

On admission, and during the hospital stay of a DJJ* youth, participating psychiatric hospitals and staff work with the DJJ* chief psychiatrist and the DJJ* program administrator to ensure appropriate treatment and discuss clinical status as necessary.

Within 24 hours of admission to an acute psychiatric hospital the hospital must assign a gender-matched nursing staff to provide constant, one-to-one supervision of the youth. Unless contraindicated by the youth's history or behavior, one-to-one supervision may be decreased to line of sight observation, by a physician's order, after the first 24 hours.

If necessary, seclusion and seclusion with restraints (four-point or five-point Velcro-type restraints) are options for youths, for brief periods of time, during their hospital stay. If seclusion or seclusion with restraints are used, the hospital must send an email to the DJJ* with an explanation of the behavior that led to the need for seclusion, the date and time seclusion began, extent of injuries (if any), and medications and dosage used (if

any). The email must be sent on the same business day if possible, but no later than 9:00 a.m. the next business day.

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Division of Juvenile Justice Youth Illness or Death

Participating psychiatric facilities must immediately notify the Division of Juvenile Justice (DJJ)* program administrator, by phone, if a youth is injured, becomes ill or dies while in their care. The phone call must include a summary of the circumstances leading to the injury, illness or death. A written report must be submitted to the DJJ* program administrator by fax within 24 hours.

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Emergency Care During Psychiatric Stay

If a Division of Juvenile Justice (DJJ)* youth requires emergency medical care while in a psychiatric hospital due to a life-threatening illness or injury, the hospital must:

- Call for an ambulance to transport the youth to the nearest emergency room (ER). The youth must be restrained for transportation in the ambulance.
- Call the nearest DJJ* facility and advise the youth is going to the ER and request the DJJ* medical watch personnel are sent to that ER location.
- Notify the ER's hospital police or security staff that a DJJ* youth is arriving in the ER and obtain the emergency phone number of hospital police or security.
- Assign a staff member to accompany the youth in the ambulance and provide one-to-one supervision at the ER until DJJ* medical watch personnel arrives. The staff member must have a working cellular phone and immediately notify hospital police or security, via emergency phone number, if the youth attempts to leave the ER. The assigned staff member must not try to stop the youth if the youth tries to escape.
- Notify the DJJ* program administrator by phone of the situation and a hospital physician must contact the DJJ* chief psychiatrist to discuss medical aspects of the situation and proposed treatment.

The DJJ* medical watch personnel will notify hospital police or security upon arrival at the ER and assume responsibility for the youth. The assigned staff member is free to return to regular duties upon arrival of DJJ* medical watch personnel.

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June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Escapes During Psychiatric Stay

Participating psychiatric facilities must immediately notify the local police department if a youth escapes during a stay. The hospital must also call the nearest Division of Juvenile Justice (DJJ)* facility and provide details regarding the escape. Additionally, the hospital must call the DJJ* program administrator and provide a summary of the escape.

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Experimental and Investigational Procedures and Medications

Psychiatric hospitals must not perform any experimental or investigational treatment, therapy or procedures, or administer any experimental or investigational medications to Division of Juvenile Justice youths. Experimental and investigational treatment is prohibited under Penal Code, Section 3502. Hospitals agree to perform or administer only those medical services that are recognized as accepted professional medical standards or as safe and effective for use in treating an illness or injury.

Non-Emergent Care During Psychiatric Stay

If a youth receives a non-emergent injury, including but not limited to, a broken bone or cut that requires sutures, the hospital must immediately notify the Division of Juvenile Justice (DJJ)* program administrator regarding the need for non-emergent medical care. In most cases, the DJJ* transports the youth to the urgent care center or other facility for assessment and treatment. Once stable, DJJ* transports the youth back to the psychiatric hospital.

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Status Reports

Hospitals must provide status reports regarding the treatment and clinical state of youths receiving acute and sub-acute psychiatric care. Status reports for acute psychiatric care must be provided to the Division of Juvenile Justice (DJJ) program administrator three times a week, on Mondays, Wednesdays and Fridays, during normal business hours (8:00 a.m. to 5:00 p.m.). Status reports for sub-acute psychiatric care must be

provided to the DJJ program administrator once a week, preferably on Wednesday, during normal business hours.

Visitation Rights, Safety and Security

Division of Juvenile Justice (DJJ)* youths are allowed visitors from a pre-approved list provided by DJJ* on the youth's arrival at the psychiatric hospital. Visitation rights may be denied if the visits are contraindicated due to the possibility of an adverse impact on the youth's mental welfare.

Participating psychiatric hospitals must allow staff physicians, registered nurses and casework specialists from the DJJ* facility to visit youths and review clinical records; however, DJJ* staff may not make any entries in the clinical records.

The psychiatric hospital must provide a locked and secured living environment for youths undergoing treatment. Additionally, youths must not smoke in or out of the secure living unit. The hospital must serve meals to youths in the locked unit.

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Written Discharge Summary

Within three days of a youth's discharge from a psychiatric hospital, the hospital must issue a written discharge summary. The discharge summary must include significant findings and events, the provider's recommendations for psychotropic medication regimen, the youth's condition on discharge, and recommendations for continuing care. If laboratory or other test results are pending, providers must provide an updated report within 24 hours of receiving the results.

Reentry Programs

California Department of Corrections and Rehabilitation (CDCR) Reentry Programs consist of Pre-Release Community Programs to include the Male to Community Reentry Program (MCRP) and Female Community Reentry Program (FCRP). These programs allow eligible offenders committed to state prison to serve the end of their sentences in the community, in lieu of confinement in state prison.

Refer to California Correctional Health Care Services (CCHCS) Reentry Programs (REPS) for contact information.

Safety and Security Procedures

Provider Type: Physicians | Hospitals | Ancillary

Typically, custody staffing consists of two correctional officers. If appropriate, the California Department of Corrections and Rehabilitation (CDCR) watch commander may increase coverage. One officer is armed with a firearm at all times. The armed officer maintains a safe distance from the patient, ensuring the weapon is not easily accessible.

The armed officer inspects the hallways prior to moving the patient to ensure it is safe to proceed. Officers must be mindful of health care facility staff and the public. Both officers make every attempt to move the patient within the facility with the least amount of disruption and attention. When escorting patients, the armed officer generally walks two steps behind and to the left of the patient. This allows the officer to observe the patient and the surrounding area for potential problems. The unarmed officer walks beside the patient. This provides officers with a tactical advantage should the inmate try to attempt a violent act or escape.

When health care providers or staff is providing medical services to the patient, the unarmed officer is responsible for providing security. The unarmed officer does not leave the patient except under the following circumstances:

- During certain medical procedures, such as X-rays or magnetic resonance imaging (MRIs). In these situations, the officer stays in an adjacent room where visual supervision of the patient is maintained.
- During examinations of a personal nature or in the delivery room, the office positions himself to provide adequate observation of what is happening to the patient for documentary purposes and personal safety reasons, including the safety of health care staff.

All patients are escorted with a minimum of leg restraints. Waist chains may be used if a need has been established, such as unusually high public safety risk level or medical procedure. In the event a patient does not have any lower appendages, officers secure an upper limb to a sturdy portion of a mobile bed. If health care staff request restraints be removed, the CDCR institution’s health care access lieutenant or watch commander must be contacted for approval.

Interaction with Patients

Correctional officers observe the interaction and conduct between patient and health care facility providers and staff. Officers ensure that inmates treat, and are treated by, health care facility providers and staff with dignity and respect. Officers also ensure no inappropriate, unprofessional interaction or misconduct with the patient occurs.

Mail and Phone Procedures

Mail Procedures

Patients are allowed to send and receive mail in conjunction with health care facility mailroom procedures. All mail is thoroughly inspected by the correctional officers prior to sending and receiving. Outgoing mail is inspected for proper institutional return address, postage and safety and security breaches. Health care providers and staff may not circumvent mail procedures and mail letters for patients. Any requests made by patients regarding mail are immediately reported to the assigned officers.

Phone Procedures

Patients are typically not permitted to use the phone or other technology equipment at any offsite facility. If the patient is in critical condition, the California Department of Corrections and Rehabilitation (CDCR) institution may approve a phone call from immediate family members.

Patient Transportation

After services have been provided, the California Department of Corrections and Rehabilitation (CDCR) determines the manner in which a patient, medical parolee or Department of Juvenile Justice (DJJ)* youth is transported back to the CDCR institutions or transferred to other health care facilities. Unless it is an emergency, providers must not transfer the patient, medical parolee or DJJ* youth without prior written authorization from the CDCR institution's chief executive officer/chief medical executive (CEO/CME), parole agent, or DJJ* facility chief medical officer (FCMO), or their designee.

*As of June 30, 2023, all Divisions of Juvenile Justice (DJJ) are closed. Juvenile offenders are no longer committed to the DJJ as of this date. Effective July 1, 2023, claims for health care services rendered to the DJJ youth should be directed to the county where the patient is located. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of California Department of Corrections and Rehabilitation (CDCR).

Room Security

At the beginning of and during each health care facility shift, correctional officers are responsible for searching patient rooms for security concerns. Officers must:

- Conduct a search and inspect each patient, ensuring the patient is in the correct room.
- Conduct a search of the patient's room ensuring there is no contraband, needles, scalpels, cellular phones, and surplus clothing. On admission to the facility, all of the patient's personal property is collected and relinquished to the California Department of Corrections and Rehabilitation (CDCR) institution's transportation team.
- Conduct a visual and physical inspection of the restraint equipment on each patient ensuring it is properly secured to the patient and bed/gurney. Visually inspect the area of the patient where the restraints are contacting the limb for signs of skin irritation. If necessary, to reduce discomfort, it is permissible to wrap a small piece of cloth around the area of the limb where the restraints are affixed.

Personnel Security

Correctional officers provide security coverage for all health care facility providers and staff who enter a patient's room.

Any time anyone is in close physical proximity to the patient, the unarmed officer enters the room and positions himself where he is best able to restrain the patient and protect staff, if necessary. Due to certain court mandates, institutional operational procedures and individual patient risk level criteria, officers may require health care facility providers and staff to identify themselves to meet documentation requirements. Providers and staff must not take this personally or perceive it as paranoia or suspiciousness. The officer's primary responsibility is to protect the public, which includes health care providers and staff.

Officers also enter isolation rooms with all facility staff. When appropriate, the officers must wear all required universal precaution equipment, such as masks and gloves. In addition, officers must inspect all food trays prior to delivery to the patient.

Visitation Rights

Patients are not allowed visitors at any facility outside the California Department of Corrections and Rehabilitation (CDCR) institution. The only exception is visits to critical or terminally ill patients. In this instance, the visitor:

- Must be an immediate family member.
- Must have a valid form of identification (ID).
- Must follow all facility regulations and visiting procedures and follow all infectious disease precaution procedures.
- Must have the approval of the facility administrator or attending physician.

Only two visitors are allowed to visit at one time and only at 30-minute intervals. Property, such as purses and diaper bags are not allowed in the room while visiting. Officers must inform visitors they are responsible for their personal property.

Service Delivery Obligations

Provider Type: Physicians | Hospitals | Ancillary

Providers must provide all clinical documentation to California Correctional Health Care Services (CCHCS) within 48 hours of a visit. The documentation be sufficient to support continuity of care within the institution, and any other required reports, including, but not limited to:

- Brief operative notes
- Clinical notes
- Discharge summaries
- Laboratory test results
- Prescriptions

Providers who fail to provide clinical documentation within 48 hours may be subject to delay in payment or denial, until documentation is received.

Providers performing hospital services must issue a written discharge summary and/or transfer summary, for a hospital discharge of a CDCR patient back to the appropriate CDCR institution, skilled nursing facility (SNF), or DJJ* facility.

The discharge or transfer summary precedes or accompanies the CDCR patient when discharged. The discharge and transfer summary must be signed by a physician and include the following essential information:

- Diagnosis
- Dietary requirements
- Imaging studies ordered
- Known allergies
- Lab tests ordered
- Medications
- Needed for follow-up appointments
- Recommendations for activities
- Referrals for additional care
- Rehabilitation potential
- Wound care required

CCHCS may request hospital providers to use a standardized discharge summary form, created by CCHCS. A sample discharge summary form can be found in the operations manual. In the event labs or other test results are pending when discharge summaries are issued, providers must provide an updated report within 24 hours of receipt for labs or test results. Upon request, network hospitals shall grant CCHCS clinical employees access to hospital medical records systems, if feasible.

Providers must give the institution chief executive officer (CEO)/chief medical officers (CMO) or the DJJ* CMO a full, dictated or written formal discharge summary within three days of the CDCR patient discharge in all cases. The discharge and/or transfer summary should include the staff physician's recommendations for continuance of care for the CDCR patient.

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Telemedicine

Provider Type: Physicians | Hospitals | Ancillary

California Correctional Health Care Services (CCHCS) considers the provision of health care service accessed through telemedicine an accepted venue for compliance with access to care. Participating providers that provide telemedicine services to improve compliance with access to care must do so in accordance with

Insurance Code Section 10123.85 and as defined in the California Business & Professions Code Section 2290.5.

The CCHCS Office of Telemedicine Services coordinates all telemedicine services, and providers are approved by the Office of Telemedicine Services prior to becoming telemedicine providers. Providers are responsible for their own telemedicine equipment and data communications outside of a California Department of Corrections and Rehabilitation (CDCR) institution.

Telemedicine providers must submit their telemedicine availability schedule to the CCHCS Office of Telemedicine Services by the first of every month. Providers must use the Provider Monthly Calendar Template (PDF) and indicate their availability for a minimum of 90 days out. Changes to posted telemedicine availability cannot be made for dates within 15 days.

Recommendations for treatment must be submitted to the CDCR institution within three business days of rendering telemedicine services. Services are not complete until recommendations are received.

All telemedicine services must adhere to patient confidentiality policies and Health Insurance Portability and Accountability Act (HIPAA) requirements. Additionally, participating providers must maintain medical record information on each patient who receives telemedicine services.

Telemedicine Provider Requirement

The provider must submit required dictated consultation reports to the institution within three business days. The dictated consultation reports must be submitted electronically in PDF (preferred), JPEG or TIFF format.

Telemedicine providers must utilize MedWeb, or its successor, to submit dictated consultation reports. Submitted dictated consultation reports must be final reports reviewed and approved by the licensed provider. Submitted dictated consultation reports must include the following:

- The provider's medical specialty.
- Full CCHCS patient identification, including CDCR number and birth date, or the Department of Juvenile Justice (DJJ)* youth identification, including CDCR number and birth date.
- Dictated consultation reports must be signed by the provider, either by hand or electronically. Provided services are considered incomplete until this report is completed.

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Contacts

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

- Availity

B

C

- California Correctional Health Care Services
- California Correctional Health Care Services - Appeals
- California Correctional Health Care Services - Disputes
- California Correctional Health Care Services Help Desk
- California Correctional Health Care Services Imaging Records Center
- California Correctional Health Care Services Office of Telemedicine
- California Correctional Health Care Services Provider Appeals and Refunds
- California Department of Corrections and Rehabilitation (CDCR) Reentry Program
- California Department of Corrections and Rehabilitation
- California Department of Corrections and Rehabilitation - Health Care Contractor's On-Site Orientation Handbook
- CorrectCare Integrated Health
- Credentialing Department

D

- Division of Juvenile Justice
- Division of Juvenile Justice Facilities
- Division of Juvenile Justice Program Administrator

E

F

G

H

I

J

K

L

M

N

- Network Providers, LLC (NPLLC)

O

P

- Prison Health Care Provider Network Provider Services Center

Q

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Z

Availity, LLC

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Contact Availity for electronic claims submission information.

800-282-4548

California Correctional Health Care Services

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For general information about California Correctional Health Care Services (CCHCS):

Providers may access the CCHCS website at www.cchcs.ca.gov for the most current contact information.

California Correctional Health Care Services (CCHCS) Reentry Programs (REPS) Contacts

CCHCS REPS Contacts

Medical Team		
Reentry Service	Fax: 916-691-3940	CDCRCCHCSREPSMedical@cdcr.ca.gov
Dental Team		
Treatment Authorizations Referral Request	Fax: 916-691-3940	CDCRCCHCSREPSDental@cdcr.ca.gov
Administrative Staff		
General Questions	916-691-0699	CDCRCCHCSREPSAdmin@cdcr.ca.gov

For information on California Department of Corrections and Rehabilitation (CDCR) Reentry Program locations, refer to **CDCR Community Reentry Locations** .

California Correctional Health Care Services - Disputes

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Providers may check the status of dispute by contacting California Correctional Health Care Services (CCHCS) at:

916-691-0699 or email at M_hisprogramsupport@cdcr.ca.gov

California Correctional Health Care Services - Appeals

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Providers may check the status of an appeal by contacting California Correctional Health Care Services (CCHCS) at:

Email: HISAppealSupport@cdcr.ca.gov.

California Correctional Health Care Services Help Desk

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For claim inquiries:

916-691-0699 or email M_hisprogramsupport@cdcr.ca.gov

California Correctional Health Care Services Imaging Records Center

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CCHCS Imaging Records Center

Submit CDs of off-site medical imaging procedures no later than three days after an exam to California Correctional Health Care Services (CCHCS) at:

CCHCS Imaging Records Center 8300 Valdez Avenue, Bay 4 Sacramento, CA 95828

California Correctional Health Care Services Office of Telemedicine

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For information about participating in the telemedicine program:

Office of Telemedicine Services PO Box 588500 Elk Grove, CA 95758

Submit telemedicine calendars by email to:

Telemedicine@cdcr.ca.gov and copy TMSpecialtyHelp@cdcr.ca.gov

For information about participating in the telemedicine program:

877-899-0561

California Correctional Health Care Services Provider Appeals and Refunds

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For provider appeals, refunds and overpayment submissions.

Submit appeals forms or the status of an appeal via Secure Email to: HISAppealSupport@cdcr.ca.gov

For refunds and/or overpayments:

Healthcare Invoicing Section Attn: Refunds, Bldg D-2 PO Box 588500 Elk Grove, CA 95758

Send United Parcel Service (UPS), Golden State Overnight (GSO) or FedEx packages to:

8260 Longleaf Drive, Bldg D-2 Elk Grove, CA 95758

California Department of Corrections and Rehabilitation

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Contact the California Department of Corrections and Rehabilitation (CDCR) for California Correctional Health Care Services (CCHCS) credentialing applications and requirements.

Credentialing and Privileging Support Unit

Customer Support Number: 916-691-0657

Fax: 916-691-0658

CredentialsVerificationUnit@cdcr.ca.gov

California Department of Corrections and Rehabilitation - Health Care On-Site Contractor's Orientation Handbook

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The Health Care On-Site Contractor's Orientation Handbook and self-certification form are located on the California Correctional Health Care Services (CCHCS) website under *Orientation Information* within *the Contracting Information* section.

CorrectCare Integrated Health

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Submit paper claims to CorrectCare Integrated Health (CCIH) at the below address.

CorrectCare Integrated Health (CCIH) P.O. Box 349026 Sacramento, CA 95834-9026

Submit additional documentation for electronic data interchange (EDI) claims via fax to the below number. Providers must use the Paperwork (PWK) Fax Cover Sheet available online at the CCIH provider website at https://tpa.correctcare.com/pp_reg/portal/ca_index/, under *User Reference* .

Fax: 844-836-7475

Credentialing Department

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The Credentialing Department is responsible for credentialing and recredentialing directly contracting providers. Attention: Provider Network Administrator 21281 Burbank Blvd Woodland Hills, CA 91367

Division of Juvenile Justice

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Effective July 1, 2023, claims for health care services rendered to DJJ youth should be directed to the county where the patient is located. Juvenile offenders are no longer committed to DJJ. Claims for services rendered on or prior to June 30, 2023, will continue to be the responsibility of CDCR.

Psychiatric hospitals must call the nearest Division of Juvenile Justice (DJJ) facility to advise a youth is going to the emergency room or to report details of an escape.

Northern California DJJ: 209-944-6406 Southern California DJJ: 805-485-7951

Division of Juvenile Justice Facilities

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N.A. Chaderjian Youth Correctional Facility (NAC) 1650 South Newcastle Road Stockton, CA 95213 209-944-6400 Fax: 209-547-0622

O.H. Close Youth Correctional Facility (OHC) 7650 South Newcastle Road Stockton, CA 95213 209-944-6391 Fax: 209-944-5612

Pine Grove Youth Conservation Camp (PINE) 13630 Aqueduct-Volcano Road Pine Grove, CA 95665 209-296-7581

Ventura Youth Correctional Facility (VYCF) 3100 Wright Road Camarillo, CA 93010 805-485-7951 Fax: 805-988-1861

Division of Juvenile Justice Program Administrator

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Contact information for the Division of Juvenile Justice (DJJ) program administrator.

Ron Wisdom, Associate Director for Healthcare,DJJ

Ron.Wisdom@cdcr.ca.gov

Network Providers, LLC (NPLLC)

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Submit completed California Correctional Health Care Services (CCHCS) Credential Verification Approval Package to NPLLC.

NPLLC, 21281 Burbank Boulevard, Woodland Hills, CA 91367

Fax: 800-525-9578

Email: PrisonNetworkSupport@healthnet.com

Prison Health Care Provider Network Provider Services Center

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The Prison Health Care Provider Network (PHCPN) Provider Services Center is available 8 a.m. to 5 p.m. Representatives can assist providers with new provider information, provider directory questions and contract terms, rates and disputes:

877-899-0561 prisonnetworksupport@healthnet.com