

# **Provider Enrollment Regulations**

## **California Code of Regulations, Title 22, Division 3**

### **Effective August 17, 2015**

#### **51000. Agent.**

“Agent” means a person who has been delegated the authority to obligate or act on behalf of an applicant or provider. For substance use disorder clinics, “agent” includes the substance use disorder medical director and any physician making determinations of medical necessity for treatment.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.1, 14043.6, 14043.75 and 14107.11, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

#### **51000.1. Applicant.**

“Applicant” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that applies to the Department for enrollment as a provider in the Medi-Cal program.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043 and 14043.1, Welfare and Institutions Code.

#### **51000.1.1. Application or Application Package.**

“Application” or “Application Package” means a completed and signed application form, including an application for continued enrollment, signed under penalty of perjury or notarized pursuant to Welfare and Institutions Code Section 14043.25, a Disclosure Statement, a Provider Agreement, and all attachments or changes in the form, statement, or agreement.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.1 and 14043.25, Welfare and Institutions Code.

#### **51000.2. Beneficiary.**

“Beneficiary” means any person certified as eligible for services under the Medi-Cal program.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14000 and 14005, Welfare and Institutions Code.

**51000.3. Business Address.**

“Business address” means the location where an applicant or provider provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary. A post office box or commercial box is not a business address. The business address for the location of a vehicle or vessel owned and operated by an applicant or provider enrolled in the Medi-Cal program and used to provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary shall either be the business address location listed on the provider's application as the location where similar services, goods, supplies, or merchandise would be provided, or the applicant's or provider's pay to address.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.1 and 14043.62, Welfare and Institutions Code; and Title 45, Code of Federal Regulations, Sections 162.408 and 162.412.

**51000.4. Business Telephone.**

“Business telephone” means the telephone number at the business address of the applicant or provider. A beeper number, answering service, biller or billing service, pager, facsimile machine, answering machine, or a cellular telephone shall not be used as the primary business telephone. A cellular telephone shall not be used as the primary business telephone, except for a provider enrolled in the Medi-Cal program pursuant to Welfare and Institutions Code Section 14043.15(b)(2).

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.15 and 14043.7, Welfare and Institutions Code.

**51000.5. Capital.**

“Capital” means the total of all money invested in, and property or services contributed to, an applicant's or provider's business enterprise for the purpose of starting, acquiring, equipping, and operating the applicant's or provider's business enterprise.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14125.8, Welfare and Institutions Code.

**51000.6. Change of Ownership.**

“Change of Ownership” means:

- (a) For a partnership, the removal, addition, or substitution of a partner.
- (b) For an unincorporated sole proprietorship, the transfer of title and property to another person.
- (c) For a corporation, the merger of the applicant's or provider's corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the applicant's or provider's corporation does not constitute a “change of ownership” but may constitute a “change of ownership or control interest,” as defined

in Section 51000.15, and may require disclosure under Section 51000.35, or a reporting of changed or additional information pursuant to Section 51000.40.

(d) For a lease, the lease of all or part of an applicant's or provider's facility constitutes a change of ownership of the leased portion.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.26 and 14043.27, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

#### **51000.6.1. Deactivate.**

“Deactivate” means the provider's number, including all business addresses used by the provider to provide health care services, goods, supplies, or merchandise directly or indirectly to Medi-Cal beneficiaries shall no longer be used to bill the Medi-Cal Program on or after the effective date of the deactivation.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.36, 14043.37, 14043.45, 14043.62 and 14043.7, Welfare and Institutions Code.

#### **51000.7. Enrolled or Enrollment in the Medi-Cal Program.**

“Enrolled or enrollment in the Medi-Cal program” means authorized under any processes by the Department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a Medi-Cal beneficiary. For substance use disorder clinics, “enrolled or enrollment in the Medi-Cal Program” and “Drug Medi-Cal certification” shall have the same meaning.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.1, 14043.2, 14043.25, 14043.26, 14043.29 and 14043.65, Welfare and Institutions Code.

#### **51000.8. Group Provider Number.**

“Group Provider Number” means the unique identification number used by a provider group applicant to obtain reimbursement from the Medi-Cal program.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.45, Welfare and Institutions Code.

#### **51000.9. Indirect Ownership Interest.**

(a) “Indirect Ownership Interest” means an ownership interest in any entity that has an ownership interest in the applicant or provider. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or provider.

(b) The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the applicant or provider, A's

interest equates to an 8 percent indirect ownership interest in the applicant or provider and shall be reported pursuant to Section 51000.35. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the applicant or provider, B's interest equates to a 4 percent indirect ownership interest in the applicant or provider and need not be reported.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

#### **51000.9.5. Licensed Substance Use Disorder Treatment Professional.**

“Licensed Substance Use Disorder Treatment Professional” means an individual that provides medically necessary, clinical services prescribed for beneficiaries admitted, registered, or accepted for care by the substance use disorder clinic and is either:

- (a) A physician licensed by the Medical Board of California or by the Osteopathic Medical Board of California; or
- (b) A psychologist licensed by the Board of Psychology; or
- (c) A clinical social worker or marriage family therapist licensed by the California Board of Behavioral Sciences.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14133 and 14133.1, Welfare and Institutions Code.

#### **51000.10. Line of Credit.**

“Line of Credit” means a right granted by an applicant or provider to any other person or entity to defer payment to applicant or provider for the purchase of services, goods, supplies, or merchandise, from applicant or provider up to a predetermined number or amount of services, goods, supplies, or merchandise, or a predetermined amount of money.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14125.8, Welfare and Institutions Code.

#### **51000.10.1. Location.**

“Location” means a street, city, or rural route address or a site or place within a street, city, or rural route address, and the city, county, state, and nine digit ZIP Code. A post office box or commercial box is not a location.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.1 and 14043.62, Welfare and Institutions Code.

**51000.11. Mailing Address.**

“Mailing address” means the address at which the applicant or provider wishes to receive general program correspondence, such as bulletin articles and Provider Manual updates. The mailing address includes the post office box number, or the street number and name, room or suite number or letter, and the city, state and 9-digit zip code.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code.

**51000.12. Managing Employee.**

“Managing employee” means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an applicant or provider.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

**51000.13. Ownership Interest.**

“Ownership interest” means the possession of equity in the capital, the stock, or the profits of the applicant or provider.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

**51000.14. Pay To Address.**

“Pay to address” means the address at which the applicant or provider wishes to receive payment for the provision of healthcare services, equipment or supplies to Medi-Cal beneficiaries. The pay to address includes the post office box number, or the street number and name, room or suite number or letter, the city, state and 9-digit zip code.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code.

**51000.15. Person with an Ownership or Control Interest.**

(a) “Person with an ownership or control interest” means a person or corporation that:

- (1) Has an ownership interest totaling 5 percent or more in an applicant or provider.
- (2) Has an indirect ownership interest equal to 5 percent or more in an applicant or provider.

(3) Has a combination of direct and indirect ownership interests equal to 5 percent or more in an applicant or provider.

(4) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least 5 percent of the value of the property or assets of the applicant or provider.

(5) Is an officer or director of an applicant or provider that is organized as a corporation.

(6) Is a partner in an applicant or provider that is organized as a partnership.

(b) To determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the applicant or provider's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and shall be reported pursuant to Section 51000.35(a). Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

#### **51000.15.1. Preenrollment Period or Preenrollment.**

"Preenrollment period" or "preenrollment" includes the period of time during which an application package for enrollment, continued enrollment, or for the addition of or change in a location is pending with the Department.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Section 14043.1, 14043.26 and 14043.4, Welfare and Institutions Code.

#### **51000.15.5. Perinatal Residential Substance Use Disorder Services Program.**

"Perinatal Residential Substance Use Disorder Services Program" has the same meaning as the term used in Section 51341.1(b)(20).

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code.

#### **51000.16. Provider Group.**

"Provider Group" means two or more rendering providers doing business together under a provider number at the same business location.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.15, 14043.26 and 14043.45, Welfare and Institutions Code.

**51000.17. Provider Group Applicant.**

“Provider Group Applicant” means more than one individual rendering provider applying to be enrolled as a provider group.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14043 and 14043.1, Welfare and Institutions Code.

**51000.18. Provider Identification Number or PIN.**

“Provider Identification Number or PIN” means the unique identification number assigned to a provider to:

- (a) Submit electronic claims for reimbursement.
- (b) Verify a beneficiary's eligibility.
- (c) Determine whether the beneficiary has met his/her share of cost, if applicable.
- (d) Complete a Medi-Service reservation or reversal.
- (e) Gain access to the provider telecommunications network for check write or claim information, payment history, or to verify procedure codes and rates of reimbursement.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14040 and 14124.5, Welfare and Institutions Code.

**51000.19. Provider.**

“Provider” shall have the same meaning as in Section 51051.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14043 and 14043.1, Welfare and Institutions Code.

**51000.20. Provider Number.**

“Provider Number” means the unique identification number used by an applicant or provider to obtain reimbursement from the Medi-Cal program. For purposes of substance use disorder clinics, the term “provider number” shall mean the national provider identifier (NPI) number.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.26 and 14043.45, Welfare and Institutions Code.

**51000.20.1. Provider Transferor.**

(a) "Provider Transferor" means a provider that joins a transferee applicant to its Medi-Cal provider agreement, including its rights to use the provider number for that location when any of the following events occur;

(1) A change of ownership as defined in Section 51000.6.

(2) A sale or transfer of 50 percent or more of the assets owned by the corporation at the location for which a provider number was issued.

(3) A cumulative change in the person(s) with an ownership or control interest of 50 percent or more since the information provided in the last complete application package that was approved for enrollment.

(4) When a new Taxpayer Identification Number is issued by the Internal Revenue Service (IRS).

(5) When the Board of Pharmacy requires a new site permit, pursuant to Chapter 9 (commencing with Section 4000) Division 2 of the Business and Professions Code.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.25, 14043.26 and 14043.45, Welfare and Institutions Code; and 42 Code of Federal Regulations, Part 489.

**51000.20.9. Rendering Practitioner.**

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 2505, 2746, 2834 and 3500, Business and Professions Code; Section 100185.5, Health and Safety Code; and Sections 14043.1, 14043.26 and 14043.47, Welfare and Institutions Code.

**51000.21. Rendering Provider.**

"Rendering provider" means an individual provider who renders healthcare services, or provides goods, supplies, or merchandise, as a member of a provider group and uses the group provider number to bill the Medi-Cal program.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code.

**51000.22. Rendering Provider Number.**

"Rendering provider number" means the unique identification number assigned to a rendering provider to identify the rendering provider on claims submitted by a provider group under a group provider number.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.45, Welfare and Institutions Code.



**51000.23. Significant Business Transaction.**

“Significant business transaction” means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lesser of \$25,000 or 5 percent of an applicant's or provider's total operating expenses.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

**51000.24. Subcontractor.**

“Subcontractor” means an individual, agency, or organization:

(a) To which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or supplies to its patients.

(b) With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

**51000.24.1. Successor Liability with Joint and Several Liability.**

“Successor Liability with Joint and Several Liability” means a provider transferor joins a transferee applicant to its Medi-Cal provider agreement, including its rights to use the provider number issued for that location.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.25, 14043.26 and 14043.45, Welfare and Institutions Code; and 42 Code of Federal Regulations, Part 489.

**51000.24.3. Substance Use Disorder Clinic.**

“Substance Use Disorder Clinic” means a location that provides substance use disorder treatment services pursuant to Article 3.2, of Chapter 7, Part 3, Division 9, of the Welfare and Institutions Code. A substance use disorder clinic includes perinatal residential substance use disorder services programs.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.24,

14124.25, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code.

**51000.24.4. Substance Use Disorder Medical Director.**

“Substance Use Disorder Medical Director” means a physician who is licensed by the Medical Board of California or the Osteopathic Medical Board of California and who meets requirements set forth in Sections 51000.70 and 51341.1(b)(28).

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14133 and 14133.1, Welfare and Institutions Code.

**51000.24.4.1. Substance Use Disorder Nonphysician Medical Practitioner.**

“Substance use disorder nonphysician medical practitioner” means an individual that provides medically necessary, clinical services prescribed for beneficiaries admitted, registered, or accepted for care by the substance use disorder clinic and is either:

- (a) A registered nurse practitioner; or
- (b) A physician assistant.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14133 and 14133.1, Welfare and Institutions Code.

**51000.24.5. Substance Use Disorder Treatment Professional.**

“Substance Use Disorder Treatment Professional” means an individual that provides clinical services prescribed for beneficiaries admitted, registered, or accepted for care by the substance use disorder clinic and is either:

- (a) An intern registered with the California Board of Behavioral Sciences or with the Board of Psychology; or
- (b) An alcohol and other drug (AOD) counselor that is registered or certified pursuant to California Code of Regulations, Title 9, Section 13035.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14133 and 14133.1, Welfare and Institutions Code.

**51000.24.8. Substance Use Disorder Treatment Services.**

“Substance Use Disorder Treatment Services” means reimbursable services provided to beneficiaries pursuant to Section 51341.1.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.24,

14124.25, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code.

**51000.25. Supplier.**

“Supplier” means any manufacturer, principal labeler, wholesaler and any other primary supplier from which an applicant or provider purchases services, goods, supplies, or merchandise, used in carrying out its responsibilities under Medi-Cal.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

**51000.25.1. Suspend.**

“Suspend” includes a deactivation, and means health care services, goods, supplies, or merchandise provided, directly or indirectly, to a Medi-Cal beneficiary shall not be reimbursed under the Medi-Cal program until the provider is reinstated by the Department.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.36, 14043.37 and 14043.7, Welfare and Institutions Code.

**51000.25.2. Transferee Applicant.**

(a) “Transferee Applicant” means an individual or entity that joins a provider transferors' Medi-Cal provider agreement including the use of the provider number issued for that location when any of the following events occur:

- (1) A change of ownership as defined in Section 51000.6.
- (2) A sale or transfer of 50 percent or more of the assets owned by the corporation at the location for which a provider number was issued.
- (3) A cumulative change in the person(s) with an ownership or control interest of 50 percent or more since the information provided in the last complete application package that was approved for enrollment.
- (4) When a new Taxpayer Identification Number is issued by the Internal Revenue Service (IRS).
- (5) When the Board of Pharmacy requires a new site permit, pursuant to Chapter 9 (commencing with Section 4000) Division 2 of the Business and Professions Code.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.25, 14043.26 and 14043.45, Welfare and Institutions Code; and 42 Code of Federal Regulations, Part 489.

**51000.26. Wholly Owned Supplier.**

“Wholly owned supplier” means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Section 14043.2, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

**51000.30. Medi-Cal Provider Application for Enrollment, Continued Enrollment, or Enrollment at a New, Additional, or Change in Location.**

(a) As a condition for enrollment, continued enrollment, or enrollment at a new, additional, or change in location, an applicant or provider shall meet the Standards of Participation specified in Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, and Division 3, Title 22, California Code of Regulations, and either:

(1) Be certified by the Department to participate in the Medi-Cal program and be a:

(A) Clinic licensed by the Department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, including a clinic, operated by a licensed clinic, that is exempt from licensure pursuant to Section 1206(h) of the Health and Safety Code; or

(B) Health facility licensed by the Department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code; or

(C) Adult day health care provider licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code; or

(D) Home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code; or

(E) Hospice licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code; or

(2) Submit to the Department a completed application package on forms specified in subsection (c), below, Section 51000.35, and Section 51000.45. These forms shall:

(A) Contain complete and accurate information.

(B) Be signed under penalty of perjury by an individual who is the sole proprietor, partner, corporate officer, or by an official representative of a governmental entity or non-profit organization, who has the authority to legally bind the applicant seeking enrollment, or the provider seeking continued enrollment, or the provider seeking enrollment at a new, additional, or change in location, as a Medi-Cal provider.

(C) Contain an original signature in ink.

(D) Be notarized by a Notary Public, unless the applicant or provider is licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, the Chiropractic Initiative Act, or is a lawfully organized group consisting of persons who are so licensed. The Certificate of

Acknowledgement signed by the Notary Public shall be in the form specified in Section 1189 of the Civil Code.

(b) For applicants or providers enrolled pursuant to subdivision (a)(2), the following events require the submission of a new complete application package:

- (1) When there is a change of ownership as defined in Section 51000.6;
- (2) When 50 percent or more of the assets owned by the corporation at the location for which a provider number has been issued are sold or transferred;
- (3) When a new Taxpayer Identification (ID) Number is issued by the IRS;
- (4) When the Board of Pharmacy requires a new site permit, pursuant to Chapter 9 (commencing with Section 4000) Division 2 of the Business and Professions Code;
- (5) When the deletion of one or more rendering providers for a provider group, results in one remaining rendering provider.
- (6) When there is a cumulative change, of 50 percent or more in the person(s) with an ownership or control interest since the information provided in the last complete application package that was approved for enrollment;

(7) When a transferee applicant meets the requirements for successor liability with joint and several liability set forth in Section 51000.32.

(c) The applicant or provider, when required pursuant to subsection (a)(2) through (b), shall complete, as applicable:

- (1) The "Medi-Cal Provider Group Application," DHS 6203 (Rev. 07/05), incorporated by reference herein; or
- (2) The "Medi-Cal Provider Application," DHS 6204 (Rev. 07/05), incorporated by reference herein; or
- (3) One of the applications from the following list, each incorporated by reference herein, which is applicable to their provider type:
  - (A) "Medi-Cal Durable Medical Equipment Provider Application," DHS 6201 (Rev. 07/05).
  - (B) "Medi-Cal Orthotics and Prosthetics Provider Application," DHS 6202 (Rev. 07/05).
  - (C) "Medi-Cal Pharmacy Provider Application," DHS 6205 (Rev. 07/05).
  - (D) "Medi-Cal Medical Transportation Provider Application," DHS 6206 (Rev. 07/05).
  - (E) "Medi-Cal Physician Application/Agreement," DHS 6210 (Rev. 07/05).
  - (F) "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers," DHCS 6216 (Rev. 2/15).
  - (G) "Medi-Cal Nonphysician Medical Practitioner and Licensed Midwife Application," DHS 6248 (Rev. 07/05).
  - (H) "Drug Medi-Cal Substance Use Disorder Clinic Application," DHCS 6001 (Rev.12/14).
  - (I) "Drug Medi-Cal Substance Use Disorder Medical Director/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Nonphysician Medical Practitioner Application/Agreement/Disclosure Statement," DHCS 6010 (Rev. 12/14).
- (4) One of the applications specified in (c)(2) or (c)(3)(G) for each nonphysician medical practitioner and licensed midwife under the supervision of a physician and surgeon.

(d) The applicant or provider, when required pursuant to subsection (a) through (b) above, shall indicate on the application:

(1) Whether the applicant or provider is requesting enrollment, or continued enrollment, enrollment at a new, additional, or change in location, or enrollment pursuant to subsection (b) above, and the provider's current provider number(s) or group number(s) if any.

(2) Whether the applicant or provider is a governmental entity or is a partnership, unincorporated sole proprietorship, corporation or limited liability company. If the applicant or provider is a partnership, a copy of the fully executed partnership agreement shall be submitted with the application.

(3) The legal name under which the applicant or provider is applying for enrollment, continued enrollment, enrollment at a new, additional or change in location, or enrollment pursuant to subsection (b) above. The legal name of the individual, partnership, provider group, association, corporation, institution, or entity, shall be the name currently on file with the Internal Revenue Service (IRS). If the applicant or provider is using a fictitious name, a copy of the Fictitious Business Name Statement, or Fictitious Name Permit, shall be submitted with the application.

(4) The business address of the applicant or provider.

(5) The business telephone number of the applicant or provider.

(6) The pay to address, if different from the business address specified on the application.

(7) The mailing address, if different from the business or pay to addresses.

(8) If the applicant or provider is an individual, the date of birth and gender of the applicant or provider.

(9) If the applicant or provider is an individual, the driver's license number or state-issued identification card number, and the state of issuance, of the applicant or provider. A copy of the applicant's or provider's valid driver's license, or state-issued identification card, shall be submitted with the application. The driver's license or state-issued identification card shall be issued within the 50 United States or the District of Columbia.

(10) The license or certificate number, or other approval to provide health care services, of the applicant or provider, including those of the rendering provider(s) in a provider group, and the effective and expiration dates. A copy of the valid license, certificate, or other approval, shall be submitted with the application.

(11) The Medicare billing number, if the applicant or provider is enrolled in the Medicare program.

(12) The Taxpayer Identification Number issued by the IRS under the name of the applicant or provider, or the social security number issued under the name of the applicant or provider. A copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification) shall be submitted with the application.

(13) The provider type of the applicant or provider and, if the applicant or provider is a physician, all of the following:

(A) A listing of his/her specialt(y)ies.

(B) The location, current status and past history of all hospital privileges.

(C) If requesting preferred provider status, documentation shall be submitted at the time of submission of the application package to show that the physician meets all

of the criteria listed in the Provider Bulletin, titled "Preferred Provider Status" dated February 2004, accessible on the Medi-Cal web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) at the Provider Enrollment link, under Statutes, Regulations and Provider Bulletins.

(14) The names, social security numbers (optional), and dates of birth of all rendering providers, if the applicant is a provider group applicant.

(15) The applicant's or provider's Seller's Permit number, if applicable. A copy of the Seller's Permit shall be submitted with the application.

(16) If the applicant intends to provide or the provider currently provides durable medical equipment as defined in Section 51160, or is a medical device retailer as defined in Section 51251, or claims reimbursement for the items listed in Section 51521 or 51526, the applicant or provider shall submit the "Medi-Cal Durable Medical Equipment Provider Application," DHS 6201 (Rev. 07/05), with the information specified in (A) through (D) below. This requirement does not apply to a provider who is authorized to submit claims for reimbursement for durable medical equipment, incontinence medical supplies, or prosthetic and orthotic appliances based on enrollment in the Medi-Cal program as a provider type other than a Durable Medical Equipment and Medical Supply Provider.

(A) A statement indicating whether the applicant or provider has a retail business open and available to the general public that is readily identifiable as a place in which the applicant or provider sells, rents or leases durable medical equipment or medical supply items either in stock on the premises, or in a warehouse under the applicant's or provider's direct control, and has an established place of business, as specified in Section 51000.60.

(B) The days and hours of operation of the applicant's or provider's business.

(C) The address of any warehouse(s) under the direct control of the applicant or provider in which the applicant or provider engages in sales, leasing, or rental of items, and if applicable, the name(s), address(es), and telephone number(s) of the person(s) who hold an ownership interest in the warehouse(s).

(D) A statement of the composition and percentage of the applicant's or provider's current business activities including whether the applicant intends to provide or provider currently provides:

1. Beds.
2. Incontinence medical supplies.
3. Ostomy supplies.
4. Infusion equipment and supplies.
5. Oxygen equipment and supplies.
6. Urinary catheters, bags and related supplies.
7. Wheelchairs.

(17) If the applicant or provider is a pharmacy as defined in Section 51106 and provides pharmaceutical services as defined in Section 51107, the applicant or provider shall submit the "Medi-Cal Pharmacy Provider Application," DHS 6205 (Rev. 07/05), with the following information:

(A) A statement indicating whether the applicant or provider has a retail established place of business that meets the criteria specified in Section 51000.60. If the applicant or provider does not have a business open and available to the general public, an explanation shall be provided.

(B) The National Council for Prescription Drug Programs (NCPDP) number.

(C) The Drug Enforcement Agency (DEA) registration certificate, and the effective and expiration dates. A copy of the DEA registration shall be submitted with the application, if controlled substances are dispensed.

(D) The California State Board of Pharmacy (CSBP) permit number and the effective date. A copy of the CSBP permit shall be submitted with the application.

(E) The name of the pharmacist-in-charge at the business address, as required by Section 4113 of the Business and Professions Code.

(F) The driver's license number or state-issued identification card, and the state of issuance, of the pharmacist-in-charge. A copy of the driver's license, or state-issued identification card of the pharmacist-in-charge shall be submitted with the application.

(G) The social security number (optional) of the pharmacist-in-charge.

(H) The information specified in subsections (d)(16)(B) through (D), above, and the percentage of the applicant's or provider's total business activities represented by the sale of prescription drugs, and meets the requirements of Welfare and Institutions Code Section 14043.34.

(I) The license number of the pharmacist-in-charge. A copy of the license issued to the pharmacist-in-charge shall be submitted with the application.

(18) If the applicant intends to provide or the provider currently provides medical transportation services as defined in Section 51151, and claims reimbursement for services as a provider of medical transportation as defined in Section 51152, or provides nonemergency medical transportation as defined in Section 51151.7, the applicant or provider shall submit the "Medi-Cal Medical Transportation Provider Application," DHS 6206 (Rev. 07/05), with the following information:

(A) For emergency transportation by ambulance, the California Highway Patrol (CHP) certificate number and the date of issuance. A copy of the CHP certificate shall be submitted with the application.

(B) For nonemergency medical transportation, as defined in Section 51151.7, by litter van or wheelchair van registered with DMV as a commercial vehicle, the vehicle identification number (VIN), make and model, year, and license plate number of each vehicle. Proof of full coverage commercial insurance for each vehicle, indicating the VIN for each covered vehicle, shall be submitted.

(C) For air ambulance transportation, the Federal Aviation Administration (FAA) certificate number. A copy of the FAA certificate and a statement on company letterhead of where the aircraft is hangared shall be submitted with the application.

(D) For each driver of nonemergency medical ground transportation vehicles and for each pilot of aircraft(s) employed by the applicant or provider:

1. Full legal name.

2. California driver's license number and the expiration date. A copy of the valid California driver's license shall be submitted with the application.

3. Driving history printout issued by the Department of Motor Vehicles (DMV). A copy of the driving history printout shall be submitted with the application.

4. Medical examination report, DL-51, issued by the DMV and the effective and expiration dates. A copy of the DL-51 shall be submitted with the application.

5. A copy of the certificates for first aid and CPR specified in Sections 51231.1 and 51231.2 shall be submitted with the application.



6. A copy of the standard pre-employment drug and alcohol lab test results shall be submitted with the application.

7. Pilot's license number of the pilot. A copy of the license shall be submitted with the application.

(E) Days and hours of business operation.

(F) Geographic area within which the city or county has issued a business license or permit to provide medical transportation services. A copy of the license or permit shall be submitted with the application.

(G) The documentation required by Sections 51231.1 and 51231.2.

(19) If the applicant intends to provide or the provider currently provides lab services as defined in Section 51137.1, or 51137.2, a Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed and a state license or registration shall be submitted. If the applicant or provider performs a test included within the 80000 series of the Physician's Current Procedural Terminology (CPT) codes, a CLIA certificate appropriate for the level of testing performed shall also be submitted if the applicant or provider performs or submits claims for any of the following CPT codes: 78110, 78111, 78120, 78121, 78122, 78130, 78160, 78191, 78270, 78271 and 78272. A copy of the CLIA certificate and the state license or registration shall be submitted with the application.

(20) If the applicant or provider is a nonphysician medical practitioner or licensed midwife as defined in Sections 51170, 51170.1, 51170.2, 51170.3 and 51191, the applicant or provider shall submit the "Medi-Cal Nonphysician Medical Practitioner and Licensed Midwife Application," DHS 6248 (07/05) with the following information:

(A) For the nonphysician medical practitioner and licensed midwife:

1. The license/certification number of the applicant or provider, and the effective and expiration dates. A copy of the valid license or certificate shall be submitted with the application.

2. Date first employed by employing provider including verification of employment.

3. Maximum work hours per week at this location.

4. Hours of supervision per week at this location.

5. For nurse practitioners, the duration of the nurse practitioner training program and the name of the school providing the training program, or equivalent experience.

(B) For the employing provider:

1. Legal Name that is currently on file with the Internal Revenue Service (IRS).

2. Medical License Number. A copy of the valid license shall be submitted with the application.

3. Provider number.

4. Business address.

5. Type of facility at the business address.

6. Type of service delivered at the business address.

7. Business telephone number.

8. Other Medi-Cal provider(s), if any, for whom the applicant currently works, including the name, provider number, business address of each employing provider and the maximum hours per week the applicant works.

(C) For the supervising provider:

1. Legal Name that is currently on file with the Internal Revenue Service (IRS).
2. Medical License Number. A copy of the valid license shall be submitted with the application.
3. Provider number.
4. Driver's license number or state-issued identification card number, and the state of issuance, of the applicant or provider. A copy of the applicant's or provider's valid driver's license, or state-issued identification card, shall be submitted with the application. The driver's license or state-issued identification card shall be issued within the 50 United States or the District of Columbia.
5. Business telephone number.
6. Type of practice/specialty.
7. Name of each nonphysician medical practitioner or licensed midwife supervised, the provider type, and the maximum number of hours worked.

(21) For the individual signing the application, who shall have the authority to legally bind the applicant or provider seeking enrollment, continued enrollment, enrollment at a new, additional, or change in location, or enrollment pursuant to subsection (b) above, the following shall be provided:

- (A) The full legal name and title.
- (B) Date of birth.
- (C) Gender.
- (D) Social security number (optional).
- (E) The driver's license number or state-issued identification card number and state of issuance. The driver's license or state-issued identification card shall be issued within the 50 United States or the District of Columbia. A copy of the valid driver's license, or state-issued identification card, shall be submitted with the application.

(22) If the applicant or provider is a substance use disorder clinic, the applicant or provider shall comply with Sections 51341.1, 51490.1, 51516.1, and shall submit a "Drug Medi-Cal Substance Use Disorder Clinic Application," DHCS 6001 (Rev. 12/14) with the following information and documentation:

- (A) A list of all substance use disorder treatment professionals, licensed substance use disorder treatment professionals, and substance use disorder nonphysician medical practitioners, including:
  1. Whether each staff member is licensed, certified, or registered, and if so, the licensing, certifying, or registering organization, also include the effective date and expiration date of each individuals licensure, certification, or registration.
  2. Proof of certification, or registration of all substance use disorder treatment professionals, as required by California Code of Regulations, Title 9, Section 13010.
  3. The NPI of each licensed substance use disorder treatment professional, and substance use disorder nonphysician medical practitioner, and if applicable, each substance use disorder treatment professional.
- (B) Whether the applicant or provider provides residential services at the business address. If the applicant or provider provides residential services but is not licensed by the Department or another governmental agency, an explanation shall be included with the application.

(C) If the applicant or provider provides residential substance use disorder treatment services, a valid residential license shall be submitted with the application.

(D) If the applicant is providing narcotic treatment services, a copy of the valid Narcotic Treatment Program license.

(E) The service modalities provided by the applicant or provider.

(F) Upon the Department's request, if the applicant or provider is a governmental entity, corporation, or limited liability company, a copy of current board minutes that contains the name of the individual authorized to sign on behalf of the applicant or provider.

(G) For the Substance Use Disorder Medical Director:

1. Legal name;
2. Medical license number and a copy of the valid license; and
3. NPI number.

(23) If the applicant or provider is a substance use disorder medical director, the applicant or provider shall submit the "Drug Medi-Cal Substance Use Disorder Medical Director/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Nonphysician Medical Practitioner Application/Agreement/Disclosure Statement," DHCS 6010 (Rev. 12/14) with the name and address of each substance use disorder clinic overseen by the substance use disorder medical director applicant or provider.

(e) The applicant or provider shall comply with all state and local laws and ordinances regarding business licensing and operations, and shall obtain all state and local licenses and permits necessary to provide the services, goods, supplies, or merchandise being provided or services being rendered by the applicant or provider. A copy of each license and permit shall be submitted with the application. Failure to obtain and maintain all necessary licenses and permits, including but not limited to, a business license, a fictitious name statement, a seller's permit, or a pharmacy or home medical device retailer license, shall result in the disapproval of an applicant's application, or the temporary suspension and deactivation of the provider's number.

(f) The applicant or provider shall obtain and show evidence of maintaining:

- (1) Worker's Compensation insurance as required by state law;
- (2) Liability insurance that covers premises and operation; and

(3) For any individual licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, Professional Liability Insurance coverage.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.45, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14043.15, 14043.2, 14043.25, 14043.26, 14043.36, 14043.37, 14043.62, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code; and Title 45, Code of Federal Regulations, Sections 162.408 and 162.412.

**51000.31. Medi-Cal Provider Group or Rendering Provider Application for Enrollment, Continued Enrollment or Enrollment at a New, Additional or Change in Location.**

(a) The provider group applicant or provider group shall;

(1) Submit a provider group application package pursuant to Section 51000.30(a) through (b) that lists all rendering providers at the business address for which the application package is submitted.

(2) Cease using the provider group number to submit claims whenever the deletion of one or more rendering provider results in less than two remaining rendering providers.

(b) A rendering provider shall:

Apply for enrollment in the Medi-Cal program by submitting a "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers," DHCS 6216 (Rev. 2/15) pursuant to Section 51000.30 if not already currently enrolled as a Medi-Cal provider.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.15, 14043.2, 14043.25 and 14043.26, Welfare and Institutions Code.

### **51000.32. Requirements for Successor Liability with Joint and Several Liability.**

(a) A provider transferor may elect successor liability with joint and several liability by meeting both of the following conditions:

(1) By letter postmarked no later than five days after the occurrence of any event listed in Section 51000.30(b), the provider transferor and the transferee applicant shall submit to the Department the "Successor Liability with Joint and Several Liability Agreement," DHS 6217 (11/05), signed and dated by both, which includes the following information:

(A) The legal name of provider transferor which shall be the name currently on file with the Internal Revenue Service (IRS).

(B) Current provider number for the location affected.

(C) Fictitious business name of the provider transferor, if applicable.

(D) The legal name of transferee applicant which shall be the name currently on file with the Internal Revenue Service (IRS).

(E) Current provider number(s) of transferee applicant, if applicable.

(F) Fictitious business name of the transferee applicant, if applicable.

(G) A statement signed and dated by both the provider transferor and the transferee applicant wherein they accept joint and several liability for all debts arising from the Medi-Cal provider agreement applicable to the location for which a provider number was issued by the Department.

(2) The transferee applicant shall submit to the Department within 35 days of the occurrence of any event listed in Section 51000.30(b), a complete application package pursuant to Section 51000.30.

(b) Notwithstanding the Provider Bulletin, titled "Effective Date of Enrollment," dated June 2004, accessible on the Medi-Cal web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) at the Provider Enrollment link, under Statutes, Regulations and Provider Bulletins, if the transferee applicant is enrolled based on an application submitted pursuant to Section 51000.30(b), the effective date of enrollment shall be the date on the notice and the provider transferor's provider number shall be deactivated effective that date.

(c) If an application submitted pursuant to 51000.30(b) is denied based on the transferee applicant's failure to meet the criteria specified in Section 51000.50(a), the provider transferor's Medi-Cal provider agreement along with the provider number originally issued for that location shall be deactivated as of the date of the occurrence of any event listed in Section 51000.30(b). Both the provider transferor and the transferee applicant shall be jointly and severally liable to the Department for all amounts paid for services, goods, supplies, or merchandise, provided directly or indirectly, to a Medi-Cal beneficiary after that date.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.15, 14043.2, 14043.25 and 14043.26, Welfare and Institutions Code; and 42, Code of Federal Regulations, Part 489.

### **51000.35. Disclosure Requirements.**

(a) The applicant or provider shall disclose all the information required by 42, Code of Federal Regulations, Sections 455.104, 455.105 and 455.106, on the following forms incorporated by reference herein, using whichever form is applicable, and shall submit the disclosure statement with the application required by Sections 51000.30 and 51000.40:

- (1) "Medi-Cal Disclosure Statement," DHCS 6207 (Rev. 2/15); or
- (2) "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers," DHCS 6216 (Rev. 2/15); or
- (3) "Drug Medi-Cal Substance Use Disorder Medical Director/Licensed Substance Use Disorder Treatment Professional/Nonphysician Medical Practitioner Application/Agreement/ Disclosure Statement," DHCS 6010 (Rev. 12/14).

(b) The disclosure statement shall include all of the following:

- (1) The name, address, and title of all:
  - (A) Managing employees;
  - (B) Persons with an ownership or control interest in the applicant or provider and the percentage of that ownership or control interest;
  - (C) Persons with an ownership or control interest in any subcontractor in which the applicant or provider has a direct or indirect ownership of 5 percent or more and the percentage of that ownership or control interest; and
  - (D) Board members and officers, if the applicant or provider is a nonprofit entity.
- (2) Whether any of the persons named in subsection (b), above, is related to another such as spouse, parent, child or sibling.
- (3) The name and address of any other health care provider in which a managing employee, board member, officer, or a person(s) with an ownership or control interest in the applicant or provider also has an ownership or control interest. This requirement applies to the extent that the applicant or provider can obtain this information by requesting it in writing from the health care provider. The applicant or provider shall:
  - (A) Keep copies of all these requests and the responses to them.
  - (B) Make them available to the Department upon request.
  - (C) Advise the Department when there is no response to a request.
- (4) The name and address of each person(s) with an ownership or control interest in any subcontractor with whom the applicant or provider has had business

transactions involving health care services, goods, supplies or merchandise related to the provision of services to a beneficiary that total more than \$25,000 during the 12-month period immediately preceding the date of the application, or immediately preceding the date on the Department's request for such information.

(5) Any significant business transactions between the applicant or provider and any wholly owned supplier, or between the applicant or provider and any subcontractor, during the 5-year period ending on the date of the application, or ending on the date of the written request by the Department for such information.

(6) The identity of any person(s) who has ownership or control interest in the applicant or provider, or is an agent or managing employee of the applicant or provider, who has within the previous ten years of the date of the application package:

(A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program; or

(B) Been found liable in any civil proceeding involving fraud or abuse in any government program; or

(C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

(c) The applicant or provider shall also state on the applicable application identified in subsection (a):

(1) Whether the applicant or provider has ever participated in the Medi-Cal program as a provider and, if applicable, the names under which the applicant or provider participated, and all provider numbers previously assigned to the applicant or provider.

(2) Whether the applicant or provider has ever participated in other states' Medicaid programs as a provider and, if applicable, the name of the state(s), the name(s) under which the applicant or provider participated, and the provider number(s).

(3) Whether the applicant or provider has ever been suspended from a Medicare or Medicaid program and, if applicable:

(A) The provider number(s), including rendering provider number(s) and group provider number(s), assigned to the applicant or provider that was/were suspended.

(B) The effective date(s) of the suspension(s).

(C) If the applicant or provider was suspended and subsequently reinstated, the date(s) of the reinstatement(s) and a copy of the letter(s) of reinstatement shall be included with the application.

(4) Whether the license, certificate, or other approval to provide health care, of the applicant or provider has ever been suspended or revoked, or whether the applicant or provider has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate or approval while a disciplinary hearing on that license, certificate or approval was pending. And, if the applicant is a pharmacy, whether the license of the pharmacist-in-charge has ever been suspended or revoked, or whether the pharmacist-in-charge has otherwise lost his/her license, or surrendered his/her license while a disciplinary hearing on his/her license was pending. If applicable, the applicant or provider shall indicate the state(s) in which the action(s) against his/her license occurred, or occurred against the license of the pharmacist-in-charge, and the effective date(s) of the licensing authority's order(s). The applicant or provider shall provide

written confirmation from the licensing authority that his/her professional privileges, or those of the pharmacist-in-charge, have been restored.

(5) Whether the license, certificate or other approval to provide health care of the applicant or provider has been disciplined by any licensing authority. And, if the applicant or provider is a pharmacy, whether the Board of Pharmacy license of the pharmacist-in-charge has ever been disciplined by any licensing authority. If applicable, the applicant or provider shall indicate what action(s) was/were taken against his/her license, or what action(s) was/were taken against the license of the pharmacist-in-charge, where the action(s) against his/her license was/were taken, or was/were taken against the license of the pharmacist-in-charge, and the effective date(s) of the licensing authority's decision(s).

(6) The driver's license number for each person who has a direct or indirect ownership interest totaling 5 percent or more in the applicant or provider. A copy of the driver's license of such persons shall be submitted with the application. If such persons does not have a driver's license, a copy of his/her state-issued identification card shall be submitted.

(7) If the applicant intends to sell, or the provider currently sells incontinence medical supplies:

(A) A statement of all sources of capital of the applicant or provider.

(B) The names and addresses of all manufacturers, suppliers and other providers with whom the applicant or provider has any type of business relationship relative to the provision of services, goods, supplies, or merchandise, to Medi-Cal beneficiaries.

(C) The names and addresses of all persons and entities to whom the applicant or provider has extended a line of credit of \$5,000 or more.

(d) Each applicant or provider shall submit a new disclosure statement to the Department within 35 days of any change to the information previously submitted to the Department on any disclosure statement as required by this Article. When there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, since the information provided in the last completed application package that was approved for enrollment, a new application package is required pursuant to Section 51000.30. Changes of less than 50 percent shall be reported pursuant to Section 51000.40.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, ,14043.26, 14043.27, 14043.36 and 14125.8, Welfare and Institutions Code; 42, U.S.C., Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42, Code of Federal Regulations, Part 455.

#### **51000.40. Reporting of Additional or Changed Information to Provider Applications.**

(a) A provider, including a provider group, shall report to the Department within 35 days of any addition or change in the information previously submitted in the application package.

(b) A provider, including a provider group, shall complete the form "Medi-Cal Supplemental Changes," DHCS 6209 (Rev. 12/14), incorporated by reference herein, to add or change the following information, or to request the following actions:

(1) "Pay to", unless the provider is a substance use disorder clinic, or "mailing" address.

(2) Business telephone number.

(3) Managing employee.

(4) Pharmacist-in-charge, if the provider is a pharmacy.

(5) Medicare billing number.

(6) Business activities, if the provider currently provides durable medical equipment and/or incontinence medical supplies and:

(A) The change requires the issuance of a new license, permit, or certificate; or

(B) The provider is adding or deleting incontinence medical supplies.

(7) Name under which the provider or provider group is doing business (DBA).

(8) CLIA number.

(9) Deactivation of a provider number.

(10) Re-issuance of a Provider Identification Number (PIN), unless the provider is a substance use disorder clinic.

(11) For provider of medical transportation services:

(A) Vehicle or aircraft information.

(B) Driver or pilot information, or the addition of information on a new driver or pilot.

(C) The days and/or hours of operation of the applicant's or provider's business.

(D) The geographic area(s) served.

(12) A change of less than 50 percent in the person(s) with an ownership or control interest, as defined in Section 51000.15, of the provider, or provider group that does not result in a new Taxpayer Identification Number being issued by the IRS. Any cumulative change of 50 percent or more in the person(s) with an ownership or control interest, since the information provided in the last complete application package was approved for enrollment, requires a new application required pursuant to Section 51000.30(b)(6).

(13) Specialty Code.

(14) For a substance use disorder clinic the following additional actions:

(A) A change of the substance use disorder medical director or physicians making medical necessity determinations for beneficiaries.

(B) Deletion or addition of service modalities.

(C) A change of any substance use disorder treatment professional or licensed substance use disorder treatment professional providing counseling services.

(c) A nonphysician medical practitioner or licensed midwife shall complete the "Medi-Cal Nonphysician Medical Practitioner and Licensed Midwife Application," DHS 6248 (Rev. 07/05), to report to the Department any change in information previously submitted, as required pursuant to Section 51000.30(d), to add or change the following information, or to request the following actions:

(1) Delete a nonphysician medical practitioner or licensed midwife;

(2) Change the supervising physician, when the employing provider remains the same;



- (3) Change the hours of supervision;
- (4) Change the maximum hours worked per week.
- (d) The Department may require the provider to submit a new application package when the provider uses the form "Medi-Cal Supplemental Changes," DHCS 6209 (Rev. 12/14) to report information not listed in subsection (b) above.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.15, 14043.2, 14043.25 and 14043.26, Welfare and Institutions Code.

#### **51000.45. Provider Agreement.**

An applicant or provider shall sign and submit one of the following provider agreements, as applicable:

- (a) "Medi-Cal Provider Agreement," DHS 6208 (Rev. 05/05), incorporated by reference herein.
- (b) "Medi-Cal Physician Application/Agreement," DHS 6210 (Rev. 07/05), incorporated by reference herein.
- (c) "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers," DHCS 6216 (Rev. 2/15) incorporated by reference herein.
- (d) "Drug Medi-Cal Provider Agreement," DHCS 6009 (Rev. 12/14), incorporated by reference herein.
- (e) "Drug Medi-Cal Substance Use Disorder Medical Director/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Nonphysician Medical Practitioner Application/Agreement/Disclosure Statement," DHCS 6010 (Rev. 12/14).

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.25 and 14123.25(a), Welfare and Institutions Code; 42 U.S.C. Sections 1320a-3, 1320a-7, 1396a(a)(38), 1396b(i)(2); and 42 Code of Federal Regulations Parts 431 and 455.

#### **51000.50. Application Review Criteria and Notice of Department Action.**

- (a) The Department shall review the applicant's or provider's completed application package for enrollment, continued enrollment, enrollment at a new, additional, or change in location, or enrollment pursuant to Section 51000.30(b) in the Medi-Cal program. The applicant or provider shall meet the following requirements for enrollment in the Medi-Cal program:
  - (1) The application package shall be signed and notarized if required by Section 51000.30(a)(2).
  - (2) The information specified in Sections 51000.30, 51000.35, and 51000.45, and all required submittals and attachments to the application package have been received by the Department.
  - (3) The applicant or provider has a valid license, certificate, or other approval necessary to perform the healthcare services or to provide the goods, supplies, or

merchandise within the applicable provider of service category or subgroup of that category.

(4) The applicant or provider meets all applicable standards for participation in the Medi-Cal program specified in Chapter 7 (commencing with section 14000) and Chapter 8 (commencing with 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, and Division 3, Title 22, California Code of Regulations.

(5) The applicant or provider has obtained all state and local licenses, permits, or authorizations necessary to operate a business at the business address for which the application package is submitted and to perform the health care services or to provide the goods, supplies, or merchandise with the applicable provider of service category or subgroup of that category.

(6) All fines, and debts due and owing, including overpayments and penalty assessments, to any federal, state, or local government entity that relates to Medicare, Medicaid, Medi-Cal, or any other federal and state health care program, have been paid, or satisfactory arrangements have been made to fulfill the obligation or the fine or debt has been excused by legal proceedings.

(7) No applicant, provider, person with an ownership or control interest in the applicant or provider, or person who is a director, officer, or managing employee of an applicant or provider, has been convicted of any felony, or convicted of any misdemeanor involving fraud or abuse in any government program, related to neglect or abuse of a patient in connection with the delivery of a healthcare item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding, or has entered into a settlement in lieu of conviction for fraud or abuse in any government program within ten years of the date of the application package.

(8) No applicant, provider, person with an ownership or control interest in the applicant or provider, or person who is a director, officer, or managing employee of an applicant or provider shall be under investigation for any healthcare related fraud or abuse at the time of the application for enrollment, continued enrollment, enrollment at a new, additional, or change in location, enrollment pursuant to Section 51000.30(b), or during the preenrollment period.

(9) The applicant or provider has satisfactorily corrected any discrepancies in the application package or identified in a background check, preenrollment inspection or unannounced visit within the time limit specified by the Department. If the applicant or provider cannot satisfactorily correct one or more discrepancies because they occurred in the past, then the application shall be denied.

(10) The applicant or provider has satisfactorily demonstrated to the Department that the business address for which the application package was submitted is an established place of business as specified in Section 51000.60, at the time of application and at the time of any background check, preenrollment inspection or unannounced visit.

(11) If applicable, the period of time during which an applicant or provider has been barred from reapplying has passed.

(12) The information submitted by the applicant or provider is accurate and complete.

(b) Except as provided in subsection (c), within 30 days of receipt of an application package, the Department shall provide written notice to inform the applicant or provider that either:

(1) A moratorium has been imposed pursuant to Welfare and Institutions Code, Section 14043.55 or 14125.8, on the enrollment of providers in the specific provider of service category for which the applicant or provider has applied. If a moratorium has been imposed, the Department shall return the application package to the applicant or provider with the notice.

(2) The Department has received the applicant's or provider's application package and shall evaluate the application package based upon the criteria contained in this Chapter and its governing statutes.

(c) Within 15 days of receipt of an application package from a physician, or a group of physicians, licensed by the Medical Board of California or the Osteopathic Medical Board of California, the Department shall provide written notice to inform the applicant or provider that the Department has received the applicant's or provider's application package.

(d) An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet all of the criteria listed in the Provider Bulletin, titled "Preferred Provider Status", dated February 2004, accessible on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) at the Provider Enrollment link, under Statute, Regulations, and Provider Bulletins. If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(e) Except as provided in subsection (f) within 180 days of receipt by the Department of an application package, or within 180 days from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider, the Department shall give written notice to the applicant or provider of one of the following:

(1) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice; or

(2) The application package is incomplete, describing which information is required, or which attachments are outstanding and/or inadequate. The application package shall be returned at the time of this notice to the applicant, who may re-submit the application package at any future date. When an application package is re-submitted, it may include the materials previously submitted along with the materials necessary to correct the outstanding and/or inadequate information, provided the materials are current and valid at the time of re-submission; or

(3) The Department is exercising its authority under Welfare and Institutions Code Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits; or

(4) The application package is denied based on the applicant's or provider's failure to meet the criteria specified in subsection (a), or failure to comply with the requirements specified in this Chapter or its governing statutes.

(f) Notwithstanding subsection (e), within 90 days of receipt by the Department of an application package from a physician or group of physicians licensed by the Medical

Board of California or the Osteopathic Medical Board of California, or within 90 days from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider, the Department shall give written notice to the applicant or provider that either paragraph (1), (2), (3) or (4) of subsection (e) applies, or shall on the 91st day grant the applicant or provider provisional provider status for a period no longer than 12 months, effective from the 91 day.

(g) If the re-submitted application package is received by the Department within 60 days of the date of the notice of an incomplete application pursuant to subsection (e)(2) above, the Department shall continue to process the application package and shall, within 60 days of the receipt of the re-submitted application package, send a notice indicating one of the following actions:

(1) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice; or

(2) The Department is exercising its authority under Welfare and Institutions Code, Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits; or

(3) The application package is denied based on the applicant's or provider's failure to meet the criteria specified in subsection (a), or failure to comply with the requirements specified in this Chapter or its governing statutes.

(h) If a re-submitted application package for enrollment, continued enrollment, enrollment at a new additional or change in location, or enrollment pursuant to Section 51000.30(b), is not received by the Department within 60 days of the date of the notice of an incomplete application pursuant to subsection (e)(2) above, the application package shall be denied by operation of law pursuant to Welfare and Institutions Code Section 14043.26. If the failure to re-submit an application package is by a provider applying for continued enrollment, the provider shall be subject to immediate deactivation of all provider numbers, pursuant to Welfare and Institutions Code Section 14043.26(h)(2)(B). Nothing in this subsection prevents the provider from reapplying as a new applicant by submitting a new application package, which shall receive a new application received date.

(i) If a background check is conducted pursuant to Welfare and Institutions Code, Section 14043.37, a preenrollment inspection is conducted pursuant to Welfare and Institutions Code Section 14043.4, or an unannounced visit is conducted pursuant to Welfare and Institutions Code, Section 14043.7, prior to enrollment, continued enrollment, enrollment at a new, additional or change in location, or enrollment pursuant to Section 51000.30(b), the Department shall provide written notice to the applicant or provider of the following:

(1) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice; or

(2) Discrepancies were found with the information provided by the applicant or provider on the application package that require remediation. The applicant or provider shall have 60 days from the date of the notice to provide the requested information and documentation to the Department in order to remediate the discrepancies. If no response is received or the discrepancies are not remediated within the 60 days, the application shall be denied by operation of law pursuant to Welfare and Institutions Code Section 14043.26; or

(3) Discrepancies were found with the information provided by the applicant or provider on the application package that cannot be remediated and the application shall be denied by operation of law pursuant to Welfare and Institutions Code Section 14043.26.

(4) The application is denied based on the applicant's or provider's failure to meet the criteria specified in subsection (a), or failure to comply with the requirements specified in this Chapter or its governing statutes.

(5) A provider whose application for continued enrollment has been denied pursuant to subsection (i)(2), (i)(3), or (i)(4) above, shall prior to any hearing be subject to temporary suspension and deactivation of all provider numbers pursuant to Welfare and Institutions Code, Section 14043.2, 14043.36, 14043.37 and 14043.7.

(j) Any notice by the Department of a denial of an application package shall specify the reason(s) for denial and the administrative remedies, if any, that may be pursued by the applicant or provider.

(k) An applicant or provider whose application package has been denied for enrollment, continued enrollment, enrollment at a new, additional, or change in location, or enrollment pursuant to Section 51000.30(b), may appeal the application package denial, in accordance with Welfare and Institutions Code, Section 14043.65.

(l) An applicant or provider whose application package has been denied for failure to submit to the Department requested information or documentation pursuant to Welfare and Institutions Code Section 14043.26(h)(2)(A) or failure to remediate discrepancies identified by the Department pursuant to Welfare and Institutions Code Section 14043.26(i)(2)(A) may reapply for enrollment in the Medi-Cal program by submitting a new application package that shall be reviewed anew.

(m) An applicant or provider whose application package has been denied for failing to disclose information or for providing false information pursuant to Welfare and Institutions Code Section 14043.2, or denied because it is under investigation pursuant to Welfare and Institutions Code Section 14043.36, shall be barred from reapplying for enrollment in the Medi-Cal program for a period of three years from the date of the denial notice. The Department shall not deny enrollment to an applicant or provider whose felony or misdemeanor charges did not result in a conviction.

(n) An applicant shall not apply for enrollment within 10 years from the date of the conviction for any offense or for any act included in Welfare and Institutions Code Section 14043.36. An applicant or provider whose application package has been denied based on a conviction for any offense or for any act included in Welfare and Institutions Code Section 14043.36, shall be barred from reapplying for enrollment in the Medi-Cal program for a period of 10 years from the date of the denial notice or from the date of the final decision following an appeal from that denial.

(o) An applicant or provider whose application package has been denied based on two or more convictions for any offense or two or more acts included in Welfare and Institutions Code Section 14043.36, shall be permanently barred from applying for enrollment in the Medi-Cal program.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.26, 14043.28, 14043.36, 14043.37, 14043.4, 14043.6, 14043.65 and 14043.7,

Welfare and Institutions Code; 42 U.S.C. Sections 1320a-3, 1320a-7, 1396a(a)(38) and 1396b(i)(2); and Title 42, Code of Federal Regulations, Part 455.

**51000.51. Provisional Provider and Preferred Provisional Provider Status.**

(a) The Department shall grant provisional provider status for a period of 12 months, or preferred provisional status for a period of 18 months, subject to the provisions of Welfare and Institutions Code Sections 14043.26 through 14043.29, when:

(1) An application for enrollment of a new provider is approved.

(2) An application for continued enrollment of a provider is approved.

(3) An application for enrollment of an additional location, or change of location for a provider is approved.

(4) An application for any change pursuant to Section 51000.30(b) is approved.

(5) The Department fails to take any action listed in Section 51000.50(e) within 180 days after receiving an application package. The applicant or provider shall be granted provisional provider status, effective on the 181st day.

(b) When a provider currently enrolled in the Medi-Cal program at one or more locations, who has submitted an application package for enrollment at an additional or change in location, begins billing for services provided at an additional or change of location, using their existing provider number, the provider shall be considered to be on provisional provider status. If the provider is subject to Welfare and Institutions Code Section 14043.47(c), the provider shall submit documentation in the application package that identifies the physician providing services at every three locations.

(c) Provisional provider status or preferred provisional provider status shall be terminated, by the Department, pursuant to Welfare and Institutions Code Section 14043.27(c)(1) - (12), regardless of whether the period of time for which the provisional provider status or preferred provisional provider status was granted has elapsed.

(d) Termination of provisional provider status or preferred provisional provider status, by the Department, shall include deactivation of all provider numbers used by the provider at any location, to obtain reimbursement from the Medi-Cal program, except where the termination is based upon a ground related solely to a specific location.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.26, 14043.27, 14043.36, 14043.37, 14043.4 and 14043.7, Welfare and Institutions Code; 42 U.S.C. Sections 1320a-3, 1320a-7, 1396a(a)(38) and 1396b(i)(2); and 42 Code of Federal Regulations Part 455.

**51000.52. Provider Numbers.**

(a) When provisional provider status or preferred provisional provider status is granted, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it is issued, except for providers subject to paragraphs (1), (2), or (3) below:

(1) If the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are

rendered or delivered only at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the Department when the provisional provider status or preferred provisional provider status was granted; or

(2) If a provider submits claims under an existing provider number for services rendered at an additional or change in location, pursuant to Section 51000.51(b); or

(3) A rendering provider in a group uses only one provider number, which does not change by location or provider group.

(b) A provider number used following submission of an application pursuant to Section 51000.30(a)(2) and (b) is exclusive to the provider and shall not be transferred or used by a transferee, except when a transferee applicant meets the successor liability with joint and several liability requirements set forth in Section 51000.32.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.15, 14043.2, 14043.26, 14043.27, 14043.36, 14043.37, 14043.4, 14043.47, 14043.6, 14043.45, 14043.65 and 14043.7, Welfare and Institutions Code; 42 U.S.C. Sections 1320a-3, 1320a-7, 1396a(a)(38) and 1396b(i)(2); and 42 Code of Federal Regulations Part 455.

#### **51000.53. Deactivation of a Provider Number(s) or Location(s).**

(a) The Department shall deactivate, immediately and without prior notice, a provider's provider number(s) or location(s) used to obtain reimbursement from the Medi-Cal program, under the following circumstances:

(1) When warrants or documents mailed to a provider's mailing address, pay to address, or business address, are returned by the United States Postal Service as not deliverable.

(2) When a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year.

(3) When the person or entity that was enrolled no longer exists by operation of law or otherwise.

(4) When an application for change in location, pursuant to Welfare and Institutions Code Section 14043.26(k), is approved the prior location shall be deactivated.

(5) When the provider has a license, certificate, or other approval to provide healthcare revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, or has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate, or approval while a disciplinary hearing on that license, certificate, or approval was pending.

(6) When a provider receives written notice that it is subject to the requirement for continued enrollment pursuant to Section 51000.55 and fails to respond to the Department within the time frames required by Sections 51000.50 and 51000.55.

(7) When a provider submits a written request for termination or deactivation of its provider number(s) or location(s).

(8) When an application submitted pursuant to Section 51000.30(b) is approved, and the provider transferor and transferee applicant meet the requirements set forth in

Section 51000.32, the provider status of the transferor at that location shall be deactivated.

(9) When an application submitted pursuant to Section 51000.30(b) is denied on the transferee applicant's failure to meet the criteria specified in Section 51000.50(a), the provider transferor's provider number or location shall be deactivated.

(b) Prior to taking action to deactivate a provider's number or specific location used by a provider to obtain reimbursement from the Medi-Cal program pursuant to subsections (a)(1) and (a)(2), the Department shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program.

(c) During the provisional provider status period or preferred provisional provider status period, the Department shall deactivate a provider's number or the specific location used by a provider to obtain reimbursement from the Medi-Cal program pursuant to Welfare and Institutions Code Section 14043.27.

(d) An applicant or provider who has used one or more provider numbers to obtain reimbursement from the Medi-Cal program for a specific location and who's provider number(s) or location(s) has been deactivated pursuant to this section may appeal this action pursuant to Welfare and Institutions Code Section 14043.65.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.26, 14043.27, 14043.28, 14043.36, 14043.37, 14043.45, 14043.62 and 14043.7, Welfare and Institutions Code; 42 U.S.C. Sections 1320a-3, 1320a-7, 1396a(a)(39) and 1396b(i)(2); and 42 Code of Federal Regulations Part 455.

#### **51000.55. Requirements for Continued Enrollment.**

(a) The Department shall periodically identify a specific provider of service category or subgroup of that category that will be subject to the continued enrollment requirements of this section.

(b) The Department shall provide individual written notice to each of the providers in the specific category or subgroup of a category that has been identified for continued enrollment, and will notify those providers that they are subject to this section. This notice for continued enrollment shall be mailed to the provider's business address and mailing address on file with the Department.

(c) When a provider receives written notice for continued enrollment pursuant to subsection (b) above, the provider shall respond to the Department within 35 days from the date of the notice to declare its intent to either apply for continued enrollment or to withdraw from the Medi-Cal program. Providers that fail to respond to the Department within 35 days from the date of the notice shall be subject to termination from the Medi-Cal program and deactivation of the provider's number and each business address used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(d) Within 180 days of receipt of a declaration of a provider's intent to apply for continued enrollment in the Medi-Cal program, the Department shall send a notice transmitting instructions to that provider on how to apply for continued enrollment.



(e) Within 70 calendar days from the date of the Department's notice pursuant to subsection (d), the provider shall submit to the Department a complete application package for continued enrollment in the Medi-Cal program. The Department shall review the completed application package in accordance with Section 51000.50. Providers that fail to submit to the Department a complete application package within 70 calendar days from the date of the notice shall be subject to immediate termination from the Medi-Cal program and deactivation of the provider's number and each business address used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(f) Upon receipt of a declaration of a provider's intent to withdraw from enrollment in the Medi-Cal program, the Department shall immediately terminate the provider's enrollment in the Medi-Cal program and shall deactivate the provider's number and each business address used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(g) A provider may appeal the termination or the deactivation pursuant to this subsection in accordance with Welfare and Institutions Code, Section 14043.65.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.2, 14043.26, 14043.28, 14043.29, 14043.45 and 14043.7, Welfare and Institutions Code.

#### **51000.60. Established Place of Business Requirements.**

(a) The applicant or provider shall have an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program as relevant to his or her scope of practice or type of business. This section does not apply to an applicant or provider who is subject to Section 51000.30(a)(1)(A) - (E).

(b) Failure to have an established place of business at the time of any inspection by the Department for enrollment, continued enrollment, enrollment at a new, additional or change in location, or enrollment pursuant to Section 51000.30(b) warrants denial of an application or shall make a provider subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number and each business address used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries, effective 15 days from the date of notice to the provider.

(c) "Established place of business" means a business address of the provider or applicant that meets all of the following criteria:

(1) Is open and conducting business at the time the application is submitted for participation in the Medi-Cal program;

(2) Has the administrative and fiscal foundation to survive as a going concern. This criterion shall be shown by financial records such as a business plan, bank statements, loan documents, promissory notes, invoices, accounts receivable, business tax records, payroll records and contractual agreements;

(3) Has adequate inventory and staff to meet current and anticipated sales and service requirements for its business;

(4) Operates in compliance with Section 51000.30(e);

(5) Has Worker's Compensation insurance as required by state law;

(6) Obtains and maintains, for any individual licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, Professional Liability insurance coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000, from an authorized insurer pursuant to Section 700 of the Insurance Code;

(7) Has the necessary equipment, office supplies and facilities available to carry out its business, including storage and retrieval of all documentation as required by Section 51476;

(8) Has the necessary service agreements to process cash and credit card transactions if operating as a retail business, or has the necessary payment mechanisms to process patient billing claims if the applicant or provider is a physician/medical practice; and

(9) Unless the applicant is requesting enrollment or the provider is enrolled pursuant to Welfare and Institutions Code Section 14043.15(b)(2) the following criteria also apply;

(A) Is located in a building either owned by the applicant or provider, or the applicant or provider has obtained a signed lease agreement; or if the applicant or provider is a substance use disorder clinic located on space donated at no cost, the applicant or provider has obtained verification from the space owner that it is authorized to use the space to provide substance use disorder services.

(B) Has regular and permanently posted business hours, unless the applicant or provider is a substance use disorder clinic;

(C) Is identifiable as a medical/healthcare provider or business, by permanently attached signage that identifies the name of the provider or business as shown on the application, unless the applicant or provider is a substance use disorder clinic.

(D) Obtains and maintains Liability insurance coverage, that covers premises and operation, in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000, from an authorized insurer pursuant to Section 700 of the Insurance Code.

(d) If the applicant or provider intends to provide or currently provides durable medical equipment as defined in Section 51160, or is a medical device retailer as defined in Section 51251, or is a pharmacy as defined in Section 51106 and provides pharmaceutical services as defined in Section 51107, all criteria in subsection (a) through (c) above must be met, and the applicant or provider must additionally meet the following criteria:

(1) Provides service to the general public on a walk-in basis during regular business hours. A request for exemption from this requirement shall be stated on the application, appropriate for the services provided, and requires the approval of the Department;

(2) Has adequate inventory in stock either on the premises, or in a warehouse under the applicant's or provider's direct control, to meet current and anticipated sales volume.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.37, 14043.4, 14043.75 and 14124.5, Welfare and Institutions Code; and Section 700,

Insurance Code. Reference: Sections 14043, 14043.1, 14043.27, 14043.37, 14043.4, 14043.45, 14043.62 and 14043.7, Welfare and Institutions Code.

**51000.70. Substance Use Disorder Medical Director Utilization.**

Each substance use disorder clinic shall have a licensed physician designated as the substance use disorder medical director, who is an agent of the substance use disorder clinic. The substance use disorder medical director shall meet the following requirements:

- (a) Not be excluded from participation in any State or Federal Medicare or Medicaid program; and
- (b) Be enrolled in Medi-Cal as a substance use disorder medical director; and
- (c) Be acting in compliance with all laws and requirements of the Medi-Cal program.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75, 14043.47(c) and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14133 and 14133.1, Welfare and Institutions Code.

**51000.75. Licensed Substance Use Disorder Treatment Professional and Substance Use Disorder Nonphysician Medical Practitioner Utilization.**

Each substance use disorder clinic shall list all licensed substance use disorder treatment professionals and substance use disorder nonphysician medical practitioners, utilized at the business address, on the “Drug Medi-Cal Substance Use Disorder Clinic Application,” DHCS 6001 (Rev. 12/14). Each licensed substance use disorder treatment professional shall meet the following requirements:

- (a) Not be excluded from participation in any State or Federal Medicare or Medicaid program; and
- (b) Be enrolled in Medi-Cal as a licensed substance use disorder treatment professional or a substance use disorder nonphysician medical practitioner.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14107, 14124.1, 14124.2, 14124.24, 14124.25, 14131, 14133 and 14133.1, Welfare and Institutions Code.

**51051. Provider.**

(a) “Provider” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.

(b) Providers include, but are not limited to:

Acupuncturists  
Audiologists

Blood Banks  
Child Health and Disability Prevention Providers  
Chiropractors  
Clinical Laboratories or Laboratories  
Comprehensive Perinatal Providers  
Dental School Clinics  
Dentists  
Dispensing Opticians  
Durable Medical Equipment and Medical Supply Providers  
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Providers  
EPSDT Supplemental Services Providers  
Fabricating Optical Laboratory  
Hearing Aid Dispensers  
Home Health Agencies Hospices  
Hospital Outpatient Departments  
Hospitals  
Intermediate Care Facilities  
Intermediate Care Facilities for the Developmentally Disabled  
Licensed Midwife  
Licensed Substance Use Disorder Treatment Professionals  
Local Educational Agency Providers  
Nurse Anesthetists  
Nurse Midwives  
Nurse Practitioners  
Nursing Facilities  
Occupational Therapists  
Ocularists Optometrists  
Orthotists  
Organized Outpatient Clinics  
Outpatient Heroin Detoxification Providers  
Personal Care Service Providers  
Pharmacies/Pharmacists  
Physical Therapists  
Physicians  
Podiatrists  
Portable Imaging Services Providers  
Prosthetists  
Providers of Medical Transportation  
Psychologists Rehabilitation  
Religious Nonmedical Health Care Institutions  
Renal Dialysis Centers and Community Hemodialysis Units  
Respiratory Care Practitioners  
Rural Health Clinics  
Short-Doyle Medi-Cal Providers  
Skilled Nursing Facilities  
Speech Therapists

Substance Use Disorder Clinics  
Substance Use Disorder Medical Directors  
Substance Use Disorder Nonphysician Medical Practitioners  
Targeted Case Management Providers

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14043.75, 14100.1, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043, 14043.1, 14043.15, 14043.26, 14043.27, 14043.36, 14100.1, 14105, 14105.3, 14115.6, 14124.5, 14132, 14132.39, 14132.4, 14132.44 and 14134.5, Welfare and Institutions Code; Section 33, Chapter 456, Statutes of 1990; Section 1250(k), Health and Safety Code; Section 1206, Business and Professions Code; and Title 42 United States Code, Section 263a.

**51240. Utilization of Nonphysician Medical Practitioners.**

(a) Each primary care physician, organized outpatient clinic or hospital outpatient department which utilizes a qualified nonphysician medical practitioner shall complete a "Medi-Cal Nonphysician Medical Practitioner and Licensed Midwife Application," DHS 6248 (Rev. 07/05) for enrollment in the Medi-Cal program pursuant to Section 51000.30.

(b) The number of nonphysician medical practitioners who may be supervised by a single primary care physician shall be in accordance with applicable professional licensing statutes and regulations.

(c) A primary care physician, an organized outpatient clinic or a hospital outpatient department shall not utilize more nonphysician medical practitioners than can be supervised within the limits stated in (b).

(d) Each primary care physician organized outpatient clinic or hospital outpatient department which utilizes a nonphysician medical practitioner shall develop a Physician-Practitioner Interface specifically establishing the scope and limits of services to be rendered by, and related to the functions of, each nonphysician medical practitioner.

(1) A Physician-Practitioner Interface includes the following:

(A) In the case of registered nurses, standardized procedures, as required by Title 16, Article 7, Division 14, California Code of Regulations, commencing with Section 1470.

(B) In the case of physician assistants, a written delegation of medical services and written supervisory guidelines, as required by Section 1399.540 and Section 1399.545(e), Title 16, California Code of Regulations.

(C) All written protocols issued by collaboration between the physician and the nonphysician medical practitioner.

(D) All written standing orders of the physician.

(E) All written special orders given by the physician.

(2) Agreements reached in developing the Physician-Practitioner Interface shall be retained on file at the provider's office, readily available for review by the Department.

Note: Authority cited: Sections 10725, 14043.15, 14105 and 14124.5, Welfare and Institutions Code; and Section 20, Health and Safety Code. Reference: Sections 14043,

14043.1, 14043.2, 14043.47, 14132.4, 14132.41 and 14132.966, Welfare and Institutions Code.

**51341.1. Drug Medi-Cal Substance Use Disorder Services.**

(a) Substance use disorder services, as defined in this section, provided to a Medi-Cal beneficiary, shall be covered by the Medi-Cal program when determined medically necessary in accordance with Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Section 51159.

(b) For the purposes of this Section, the following definitions and requirements shall apply:

(1) "Admission to treatment date" means the date of the first face-to-face treatment service, as described in Subsection (d), rendered by the provider to the beneficiary.

(2) "Beneficiary" has the same meaning as in Section 51000.2.

(3) "Calendar Week" means the seven (7) day period from Sunday through Saturday.

(4) "Collateral services" means face-to-face sessions with therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

(5) "Counselor" means any of the following:

(A) A "Certified AOD Counselor," as defined in Section 13005(a)(2) of Title 9, CCR.

(B) A "Registrant," as defined in Section 13005(a)(8) of Title 9, CCR.

(6) "County" means the department authorized by the county board of supervisors to administer alcohol and substance use disorder programs, including Drug Medi-Cal substance use disorder services.

(7) "Crisis intervention" means a face-to-face contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.

(8) "Day care habilitative services" means outpatient counseling and rehabilitation services provided at least three (3) hours per day, three (3) days per week to persons with substance use disorder diagnoses, who are pregnant or postpartum, and/or to Early and Periodic Screening Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized in this Chapter.

(9) "Department" means the State of California Department of Health Care Services which is authorized to administer Drug Medi-Cal substance use disorder services. Whenever the Department contracts for Drug Medi-Cal substance use disorder services directly with a provider, the Department shall also assume the role and responsibilities assigned to the county under this section.

(10) "Face-to-face" means occurring in person, at a certified facility. Telephone contacts, home visits, and hospital visits shall not be considered face-to-face.

(11) "Group counseling" means face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served. Group counseling shall be conducted in a confidential setting, so that individuals not participating in the group cannot hear the comments of the group participants, therapist or counselor. A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

(A) For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than ten clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

(B) For day care habilitative services, group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

(12) "Individual counseling" means face-to-face contacts between a beneficiary and a therapist or counselor. Individual counseling shall be conducted in a confidential setting, so that individuals not participating in the counseling session cannot hear the comments of the beneficiary, therapist or counselor.

(13) "Intake" means the process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders utilizing the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association; and the assessment of treatment needs to provide medically necessary treatment services by a physician. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.

(14) "Medical psychotherapy" means a type of counseling service that has the same meaning as defined in Section 10345 of Title 9, CCR.

(15) "Medication Services" means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.

(16) "Naltrexone treatment services" means an outpatient treatment service directed at serving detoxified opiate addicts who have substance use disorder diagnosis by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

(17) "Narcotic treatment program" means an outpatient service using methadone and/or levoalphacetylmethadol (LAAM), directed at stabilization and rehabilitation of persons who are opiate addicted and have a substance use disorder diagnoses. For the purposes of this section, "narcotic treatment program" does not include detoxification treatment.

(18) "Outpatient drug free treatment services" means an outpatient service directed at stabilizing and rehabilitating persons with substance use disorder diagnoses.

(19) "Perinatal certified substance use disorder program" means a Medi-Cal certified program which provides substance use disorder services, as specified in Subsection (c)(4), to pregnant and postpartum women with substance use disorder diagnoses.

(20) "Perinatal residential substance use disorder services program" means a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnoses. Each beneficiary shall live on the premises and shall be supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services for pregnant and postpartum women. Supervision and treatment services shall be available day and night, seven days a week.

(21) "Physician" means a person licensed as a physician by the Medical Board of California or the Osteopathic Medical Board of California.

(22) "Postpartum" means within the eligibility period specified in Section 50260.

(23) "Postservive postpayment utilization review" has the same meaning as Section 51159(c).

(24) "Provider" means the entity certified pursuant to Section 51200 to provide Drug Medi-Cal substance use disorder services to eligible beneficiaries at its certified location(s).

(25) "Relapse" means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

(26) "Relapse trigger" means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

(27) "Substance use disorder diagnoses" are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association.

(28) "Substance Use Disorder Medical Director" has the same meaning as in Section 51000.24.4.

(A) For outpatient drug free, day care habilitative, perinatal residential and naltrexone treatment services programs the following shall apply:

(i) The substance use disorder medical director's responsibilities shall at a minimum include all of the following:

(a) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.

(b) Ensure that physicians do not delegate their duties to nonphysician personnel.

(c) Develop and implement medical policies and standards for the provider.

(d) Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.

(e) Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

(f) Ensure that provider's physicians are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of



treatment for beneficiaries and perform other physician duties, as outlined in this section.

(ii) The substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed.

(iii) A substance use disorder medical director shall receive a minimum of five (5) hours of continuing medical education in addiction medicine each year.

(B) For narcotic treatment programs, a substance use disorder medical director shall meet the requirements specified in Section 10110 of Title 9, CCR.

(29) "Support plan" means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

(30) "Therapist" means any of the following:

(A) A psychologist licensed by the California Board of Psychology.

(B) A clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences.

(C) An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences.

(D) A physician.

(31) "Unit of service" means:

(A) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services, a face-to-face contact on a calendar day.

(B) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with Section 10000 of Title 9, CCR.

(c) Drug Medi-Cal substance use disorder services for pregnant and postpartum women:

(1) Any of the substance use disorder services listed in Subsection (d) shall be reimbursed at enhanced perinatal rates pursuant to Section 51516.1(a)(3) only when delivered by providers who have been certified pursuant to Section 51200 to provide perinatal Medi-Cal services to pregnant and postpartum women.

(2) Only pregnant and postpartum women are eligible to receive residential substance use disorder services.

(3) Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

(4) Perinatal services shall include:

(A) Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792);

(B) Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);

(C) Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and

(D) Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational

training and other services which are medically necessary to prevent risk to fetus or infant).

(d) Drug Medi-Cal substance use disorder services shall include all of the following:

(1) Narcotic treatment program services, utilizing methadone and/or levoalphacetylmethadol (LAAM) as narcotic replacement drugs, including intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance use, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone and/or LAAM, as prescribed by a physician to alleviate the symptoms of withdrawal from opiates, rendered in accordance with the requirements set forth in Chapter 4 commencing with Section 10000 of Title 9, CCR.

(2) Outpatient drug free treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure, subject to all of the following:

(A) Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month.

(B) Individual counseling shall be limited to intake, crisis intervention, collateral services, and treatment and discharge planning.

(3) Day care habilitative services including intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure. Day care habilitative services shall be provided only to pregnant and postpartum women and/or to EPSDT-eligible beneficiaries as otherwise authorized in this Chapter. The service shall consist of regularly assigned, structured, and supervised treatment.

(4) Perinatal residential substance use disorder services including intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide and/or order these services within the scope of their practice or licensure.

(A) Perinatal residential substance use disorder services shall be provided in a residential facility licensed by the Department pursuant to Chapter 5 (commencing with Section 10500), Division 4, Title 9, CCR.

(B) Perinatal residential substance use disorder services shall be reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents [In accordance with 42 CFR Section 435.1009, Medicaid reimbursement is not allowed for individuals in facilities with a treatment capacity of more than 16 beds].

(C) Room and board shall not be reimbursable through the Medi-Cal program.

(5) Naltrexone treatment services including intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance use, body specimen screens, individual and group counseling, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure. Naltrexone treatment services shall only be provided to a beneficiary who meets all of the following conditions:

(A) Has a confirmed, documented history of opiate addiction.

(B) Is at least (18) years of age.

(C) Is opiate free.

(D) Is not pregnant.

(e) The Department shall do all of the following:

(1) Provide administrative and fiscal oversight, monitoring, and auditing for the provision of statewide Drug Medi-Cal substance use disorder services.

(2) Ensure that utilization review is maintained through on-site postservice postpayment utilization review.

(3) Demand recovery of payment in accordance with the provisions of Subsection (m).

(f) The county shall do all of the following:

(1) Implement and maintain a system of fiscal disbursement and controls over the Drug Medi-Cal substance use disorder services rendered by providers delivering services within its jurisdiction pursuant to an executed provider agreement.

(2) Monitor to ensure that billing for reimbursement is within the rates established for services.

(3) Process claims for reimbursement.

(g) In addition to the requirements of Section 51476 and the regulations set forth in this chapter, the provider shall:

(1) Establish, maintain, and update as necessary, an individual patient record for each beneficiary admitted to treatment and receiving services. Each beneficiary's individual patient record shall include documentation of personal information as specified in Paragraph (A) and beneficiary treatment episode information as specified in Paragraph (B) below.

(A) Documentation of personal information shall include all of the following:

(i) Information specifying the beneficiary's identifier (i.e., name, number).

(ii) Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, beneficiary's next of kin or emergency contact.

(iii) For pregnant and postpartum women, medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy.

(B) Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, as specified in Subsections (b), (c), (d) and (h), including but not limited to all of the following:

(i) Intake and admission data, including, if applicable, a physical examination.

(ii) Treatment plans.

(iii) Compliance with Subsection (h)(4).

- (iv) Progress notes.
  - (v) Continuing services justifications.
  - (vi) Laboratory test orders and results.
  - (vii) Referrals.
  - (viii) Counseling notes.
  - (ix) Discharge plan.
  - (x) Discharge summary.
  - (xi) Compliance with the multiple billing requirements specified in Section 51490.1(b).
  - (xii) Any other information relating to the treatment services rendered to the beneficiary.
  - (xiii) Evidence of compliance with requirements for the specific treatment service as described in Subsection (d).
- (2) Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
- (A) The typed or legibly printed name and signature of the therapist(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet the therapist(s) and/or counselor(s) certify that the sign-in sheet is accurate and complete.
  - (B) The date of the counseling session.
  - (C) The topic of the counseling session.
  - (D) The start and end time of the counseling session.
  - (E) A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.
- (3) Provide services.
- (4) Submit claims for reimbursement and maintain documentation specified in Section 51008.5 supporting good cause claims where the good cause results from provider-related delays.
- (h) For a provider to receive reimbursement for Drug Medi-Cal substance use disorder services, those services shall be provided by or under the direction of a physician and all of the following requirements shall apply:
- (1) Admission criteria and procedures.
    - (A) For outpatient drug free, Naltrexone treatment, day care habilitative, and perinatal residential treatment services each of the following requirements shall be met:
      - (i) The provider shall develop and document procedures for the admission of beneficiaries to treatment; and
      - (ii) The provider shall complete a personal, medical, and substance use history for each beneficiary upon admission to treatment.
      - (iii) The physician shall review each beneficiary's personal, medical and substance use history within thirty (30) calendar days of the beneficiary's admission to treatment date.
    - (iv) Physical examination requirements
      - (a) If a beneficiary had a physical examination within the twelve (12) month period prior to the beneficiary's admission to treatment date, the physician shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date. If a provider is unable to

obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

(b) As an alternative to complying with Paragraph (a) or in addition to complying with Paragraph (a) above, the physician, a registered nurse practitioner or a physician's assistant, may perform a physical examination of the beneficiary within thirty (30) calendar days of the beneficiary's admission to treatment date.

(c) If the physician has not reviewed the documentation of the beneficiary's physical examination as provided for in Paragraph (a) or the provider does not perform a physical examination of the beneficiary as provided for in Paragraph (b), then the provider shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met.

(v) Diagnosis Requirements

(a) The physician shall evaluate each beneficiary to diagnose whether the beneficiary has a substance use disorder, within thirty (30) calendar days of the beneficiary's admission to treatment date. The diagnosis shall be based on the applicable diagnostic code from the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association. The physician shall document the basis for the diagnosis in the beneficiary's individual patient record.

(b) As an alternative to complying with Paragraph (a) above, the therapist, physician assistant, or nurse practitioner, acting within the scope of their respective practice, shall evaluate each beneficiary to diagnose whether the beneficiary has a substance use disorder, within thirty (30) calendar days of the beneficiary's admission to treatment date. The diagnosis shall be based on the applicable diagnostic code from the Diagnostic and Statistical Manual of Mental Disorders Third Edition - Revised or Fourth Edition, published by the American Psychiatric Association. The individual who performs the diagnosis shall document the basis for the diagnosis in the beneficiary's individual patient record. The physician shall document approval of each beneficiary's diagnosis that is performed by a therapist, physician assistant or nurse practitioner by signing and dating the beneficiary's treatment plan.

(vi) The physician shall determine whether substance use disorder services are medically necessary, consistent with Section 51303 within thirty (30) calendar days of each beneficiary's admission to treatment date.

(B) In addition to the requirements of Subsection (h)(1)(A), for Naltrexone treatment services, for each beneficiary, all of the following shall apply:

(i) The provider shall confirm that the beneficiary meets all of the following conditions:

(a) Has a documented history of opiate addiction.

(b) Is at least eighteen (18) years of age.

(c) Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.

(d) Is not pregnant and is discharged from the treatment if she becomes pregnant.

(ii) The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results; and

(iii) The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

(C) For narcotic treatment programs, the provider shall adhere to the admission criteria specified in Section 10270, Title 9, CCR.

(2) Treatment plan for each beneficiary.

(A) For each beneficiary admitted to outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services the provider shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process. The provider shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

(i) The initial treatment plan and updated treatment plans shall include all of the following:

(a) A statement of problems to be addressed.

(b) Goals to be reached which address each problem.

(c) Action steps which will be taken by the provider, and/or beneficiary to accomplish identified goals.

(d) Target dates for the accomplishment of action steps and goals.

(e) A description of the services, including the type of counseling, to be provided and the frequency thereof.

(f) The assignment of a primary therapist or counselor.

(g) The beneficiary's diagnosis as required by Subsection (h)(1)(A)(v).

(h) If a beneficiary has not had a physical examination within the twelve month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.

(i) If documentation of a beneficiary's physical examination, which was performed during the prior twelve months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

(ii) The provider shall ensure that the initial treatment plan meets all of the following requirements:

(a) The therapist or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date.

(b) The beneficiary shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within (30) calendar days of the admission to treatment date. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

(c) The physician shall review the initial treatment plan to determine whether the services are medically necessary. This determination shall be consistent with Section 51303. If the physician determines the services in the initial treatment plan are medically necessary, the physician shall type or legibly print their name, and sign and date the

treatment plan within fifteen (15) calendar days of signature by the therapist or counselor.

(iii) The provider shall ensure that the treatment plan is reviewed and updated as described below:

(a) The therapist or counselor shall complete, type or legibly print their name, sign and date the updated treatment plan no later than ninety (90) calendar days after signing the initial treatment plan, and no later than every ninety (90) calendar days thereafter, or when a change in problem identification or focus of treatment occurs, whichever comes first.

(b) The beneficiary shall review, approve, type or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of signature by the therapist or counselor. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

(c) The physician shall review each updated treatment plan to determine whether the services are medically necessary. This determination shall be consistent with section 51303. If the physician determines the services in the updated treatment plan are medically necessary, the physician shall type or legibly print their name and, sign and date the updated treatment plan, within fifteen (15) calendar days of signature by the therapist or counselor. If the physician has not prescribed medication, a psychologist licensed by the State of California Board of Psychology may review for medical necessity, type or legibly print their name and sign and date an updated treatment plan.

(B) For narcotic treatment programs, providers shall complete initial and updated treatment plans in accordance with the requirements specified in Section 10305, Title 9, CCR.

(3) Progress notes shall be legible and completed as follows:

(A) For outpatient drug free or Naltrexone treatment services, for each individual and group counseling session, the therapist or counselor who conducted that counseling session shall record a progress note for each beneficiary who participated in the counseling session; and type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the counseling session. Progress notes are individual narrative summaries and shall include all of the following:

(i) The topic of the session.

(ii) A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.

(iii) Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session.

(B) For day care habilitative and perinatal residential treatment services, the therapist or counselor shall record at a minimum one (1) progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions. The therapist or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. Progress notes are individual narrative summaries and shall include all of the following:

(i) A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.

(ii) A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.

(C) For narcotic treatment programs, the therapist or counselor shall record progress notes in accordance with the requirements of Section 10345, Title 9, CCR.

(4) Minimum provider and beneficiary contact.

(A) For outpatient drug free, day care habilitative, perinatal residential, or Naltrexone treatment services, a beneficiary shall be provided a minimum of two (2) counseling sessions per thirty (30) day period except when the physician determines that either of the following apply:

(i) Fewer beneficiary contacts are clinically appropriate.

(ii) The beneficiary is progressing toward treatment plan goals.

(B) Narcotic treatment program providers shall provide counseling in accordance with Section 10345, Title 9, CCR. A beneficiary shall receive a minimum of fifty (50) minutes of counseling per calendar month. Waivers of this requirement shall be in accordance with Section 10345, Title 9, CCR.

(5) Continuing services shall be justified as shown below:

(A) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services:

(i) For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the therapist or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services.

(ii) For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the physician shall determine whether continued services are medically necessary, consistent with Section 51303. The determination of medical necessity shall be documented by the physician in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

(a) The beneficiary's personal, medical and substance use history.

(b) Documentation of the beneficiary's most recent physical examination.

(c) The beneficiary's progress notes and treatment plan goals.

(d) The therapist or counselor's recommendation pursuant to Paragraph (i) above.

(e) The beneficiary's prognosis.

(iii) If the physician determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment.

(B) For narcotic treatment program services, the review to determine continuing need for services shall be performed in accordance with Section 10410, Title 9, CCR.



(6) Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. In addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Subsection (p).

(A) A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.

(i) The discharge plan shall include, but not be limited to, all of the following:

(a) A description of each of the beneficiary's relapse triggers and a plan to assist the beneficiary to avoid relapse when confronted with each trigger.

(b) A support plan.

(ii) The discharge plan shall be prepared within thirty (30) calendar days prior to the date of the last face-to-face treatment with the beneficiary.

(iii) During the therapist or counselor's last face-to-face treatment with the beneficiary, the therapist or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary.

(B) The provider shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

(i) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services, the provider shall complete the discharge summary within thirty (30) calendar days of the date of the provider's last face-to-face treatment contact with the beneficiary. The discharge summary shall include all of the following:

(a) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.

(b) The reason for discharge.

(c) A narrative summary of the treatment episode.

(d) The beneficiary's prognosis.

(ii) For narcotic treatment program services, the discharge summary shall meet the requirements of Section 10415, Title 9, CCR.

(7) Except where share of cost, as defined in Section 50090, is applicable, providers shall accept proof of eligibility for Drug Medi-Cal as payment in full for treatment services rendered. Providers shall not charge fees to a beneficiary for access to Drug Medi-Cal substance use disorder services or for admission to a Drug Medi-Cal treatment slot.

(i) For each beneficiary, providers shall maintain all of the documentation in the beneficiary's individual patient record established pursuant to Subsection (g)(1) for a minimum of three (3) years from the date of the last face-to-face contact between the beneficiary and the provider. In addition providers shall maintain documentation that the beneficiary met the requirements for good cause specified in Section 51008.5, where the good cause results from beneficiary-related delays, for a minimum of three (3) years from the date of the last face-to-face contact. If an audit takes place during the three year period, the providers shall maintain records until the audit is completed.

(j) Reimbursement for Drug Medi-Cal Substance Use Disorder Services.

(1) The Department shall not reimburse a provider for services not rendered or received by a beneficiary.

(2) In order to receive and retain reimbursement for services provided to a beneficiary, the provider shall comply with the requirements listed in Subsection (i).

(3) When a beneficiary receives services from more than one provider, the Department shall reimburse only one provider for a single unit of service provided at a single certified location on a calendar day.

(4) For outpatient drug free, day care habilitative, and Naltrexone treatment services, the Department may reimburse the provider for an additional unit of service on a calendar day under either of the circumstances listed below. The additional unit of service shall be reimbursed pursuant to Section 51490.1(b) and shall be documented in the individual patient record as a separate unit of service in accordance with Subsection (h)(3).

(A) Outpatient drug free and Naltrexone for crisis intervention or collateral services; or

(B) Day care habilitative for crisis intervention.

(5) The Department shall reimburse a narcotic treatment program for services based on Section 51516.1. If the beneficiary receives less than a full month of services, the Department shall prorate reimbursement to the daily rate per beneficiary, based on the annual rate per beneficiary and a 365-day year pursuant to Section 14021.51(g) of the Welfare and Institutions Code.

(k) The Department shall conduct a postservice postpayment utilization review of Drug Medi-Cal substance use disorder services. The review shall do all of the following:

(1) Verify that the documentation requirements of Subsection (i) are met.

(2) Verify that each beneficiary meets the admission criteria, including the use of an appropriate Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association diagnostic code, and medical necessity for services is established pursuant to Subsection (h)(1)(A)(vi).

(3) Verify that a treatment plan exists for each beneficiary and that the provider rendered services claimed for reimbursement in accordance with the requirements set forth in Subsection (h).

(4) Establish the basis for recovery of payments in accordance with Subsection (m).

(l) The Department shall base its postservice postpayment utilization review findings and the amount of provider overpayments on a sampling of beneficiary and other provider records. These records shall be provided while Department personnel are on the provider's premises conducting the postservice postpayment utilization review for that site. In determining provider compliance or the amount of provider overpayments, the Department shall not consider records provided after Department personnel have left the provider's premises.

(m) In addition to the provisions of Section 51458.1(a), the Department shall recover overpayments to providers for any of the following reasons:

(1) For all providers who:

(A) Claimed reimbursement for a service not rendered.

(B) Claimed reimbursement for a service at an uncertified location.

(C) Failed to meet the requirements of Subsections (b), (c), (d), (g), (h), and (i).

(D) Used erroneous, incorrect, or fraudulent good cause codes and procedures specified in Sections 51008 and 51008.5.

(E) Used erroneous, incorrect, or fraudulent multiple billing codes and certification processes specified in Section 51490.1(b).

(2) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services if the provider received reimbursement in excess of the limits set forth in Section 51516.1(a).

(3) For narcotic treatment programs, because the provider failed to meet any of the following:

(A) The admission criteria time frames specified in Section 10270, Title 9, CCR.

(B) The time frames for treatment plan completion and for review specified in Section 10305, Title 9, CCR.

(C) The continuing treatment time frames specified in Section 10410, Title 9, CCR.

(4) For all providers who received reimbursement for an ineligible narcotic treatment program individual or group counseling session. For purposes of this subsection, "ineligible narcotic treatment program individual or group counseling session" means any of the following:

(A) The counseling session does not meet the minimum requirements set forth in Section 10345, Title 9, CCR;

(B) The counseling session is not the type specified in the treatment plan required by Section 10305, Title 9, CCR; or

(C) The frequency of counseling exceeds that specified in the treatment plan required by Section 10305, Title 9, CCR.

(5) For all providers who received reimbursement for an ineligible individual counseling session. For purposes of this subsection "ineligible individual counseling session" means an individual counseling session which does not meet the requirements specified in Subsection (b)(12) and, for outpatient drug free treatment services as specified in Subsection (d)(2)(B).

(6) For all providers who received reimbursement for an ineligible group counseling session. For purposes of this subsection, "ineligible group counseling session" means a group counseling session which does not meet the requirements specified in Subsection (b)(11) and, for outpatient drug free treatment services as specified in Subsection (d)(2)(A).

(7) For all providers who received reimbursement for an ineligible day care habilitative unit of service. For purposes of this subsection, "ineligible day care habilitative unit of service" means a unit of service that was less than three hours of service on the calendar day billed or provided to a non-pregnant, non-postpartum or non-EPSTD eligible beneficiary.

(n) The Department shall utilize the procedures contained in Section 51458.2 to determine the amount of the demand for recovery of payment.

(o) Provider noncompliance with other requirements set forth in this section shall be noted as programmatic deficiencies. The Department shall issue a report to the provider documenting any demand for recovery of payment and/or programmatic deficiencies and the provider shall submit a corrective action plan within sixty (60) calendar days of the date of the report. The plan shall do all of the following:

(1) Address each demand for recovery of payment and/or programmatic deficiency.

(2) Provide a specific description of how the deficiency shall be corrected.

(3) Specify the date of implementation of the corrective action.

(p) Providers shall inform each beneficiary of the right to a fair hearing related to denial, involuntary discharge, or reduction in Drug Medi-Cal substance use disorder services as it relates to their eligibility or benefits, pursuant to Section 50951.

(1) Providers shall advise the beneficiary in writing at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services. The written notice shall include all of the following:

(A) A statement of the action the provider intends to take.

(B) The reason for the intended action.

(C) A citation of the specific regulation(s) supporting the intended action.

(D) An explanation of the beneficiary's right to a fair hearing for the purpose of appealing the intended action.

(E) An explanation that the beneficiary may request a fair hearing by submitting a written request to:

DEPARTMENT OF SOCIAL SERVICES  
STATE HEARINGS DIVISION  
P.O. BOX 944243, MS 9-17-37  
SACRAMENTO, CA 94244-2430  
1 (800) 952-5253  
TDD 1(800) 952-8349

(F) An explanation that the provider shall continue treatment services pending a fair hearing decision only if the beneficiary appeals in writing to the Department of Social Services for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.

(2) All fair hearings shall be conducted in accordance with Section 50953.

(q) County and Provider Administrative Appeals

A provider and/or county may appeal Drug Medi-Cal dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims.

(1) Requests for first-level appeals, grievances, and complaints will be managed as follows:

(A) The provider and/or county shall initiate action by submitting a letter to:

DIVISION CHIEF  
SUBSTANCE USE DISORDERS PREVENTION, TREATMENT, AND RECOVERY  
SERVICES DIVISION  
DEPARTMENT OF HEALTH CARE SERVICES  
P.O. BOX 997413, MS-2621  
SACRAMENTO, CA 95899-7413

(i) The provider and/or county shall submit the letter on the official stationery of the provider and/or county and it shall be signed by an authorized representative of the provider and/or county.

(ii) The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim.

(B) The letter shall be submitted to the address listed in Subsection (q)(1)(A) within ninety (90) calendar days from the date the provider and/or county received written notification of the decision to disallow claims.

(C) The Substance Use Disorders Prevention, Treatment, and Recovery Services Division (SUDPTRSD) shall acknowledge the letter within fifteen (15) calendar days of its receipt.

(D) The SUDPTRSD shall inform the provider and/or county of the SUDPTRSD's decision and the basis for the decision within fifteen (15) calendar days after the SUDPTRSD's acknowledgement notification. The SUDPTRSD shall have the option of extending the decision response time if additional information is required from the provider and/or county. The provider and/or county will be notified if the SUDPTRSD extends the response time limit.

(2) A provider and/or county may initiate a second level appeal, grievance or complaint to the Office of Administrative Hearings and Appeals.

(A) The second level process may be pursued only after complying with first-level procedures and only when:

(i) The SUDPTRSD has failed to acknowledge the grievance or complaint within fifteen (15) calendar days of its receipt, or

(ii) The provider and/or county is dissatisfied with the action taken by the SUDPTRSD where the conclusion is based on the SUDPTRSD's evaluation of the merits. The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within thirty (30) calendar days from the date the SUDPTRSD failed to acknowledge the first-level appeal or from the date of the SUDPTRSD's first-level appeal decision.

(B) All second-level appeals made in accordance with this section shall be directed to:

OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS  
1029 J STREET, SUITE 200  
SACRAMENTO, CA 95814

(C) In referring an appeal, grievance, or complaint to the Office of Administrative Hearings and Appeals, the provider and/or county shall submit all of the following:

(i) A copy of the original written grievance or complaint sent to the SUDPTRSD.

(ii) A copy of the SUDPTRSD's report to which the appeal, grievance, or complaint applies.

(iii) If received by the provider and/or county, a copy of the SUDPTRSD's specific finding(s), and conclusion(s) regarding the appeal, grievance, or complaint with which the provider and/or county is dissatisfied.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14021, 14021.3, 14021.5, 14021.6, 14021.30, 14021.51, 14043.75, 14124.1, 14124.24, 14124.26 and 14124.5, Welfare and Institutions Code; Statutes of 2011, Chapter 32, and Statutes of 2012, Chapter 36. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.20,

14124.21, 14124.24, 14124.25, 14124.26, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code; Sections 436.122, 456.21, 456.22 and 456.23, Title 42, Code of Federal Regulations; Statutes of 1996, Chapter 162, Items 4200-101-0001 and 4200-102-0001; and Statutes of 2011, Chapter 32, and Statutes of 2012, Chapter 36.

**51451. Inclusions, Exclusions and Suspensions.**

All individuals, partnerships, clinics, groups, associations, corporations or institutions meeting the requirements specified in the Definitions (Article 2 of Chapter 3 of these Regulations) and Standards for Participation (Article 3 of Chapter 3 of these Regulations) may participate in the California Medical Assistance Program except where such individuals, partnerships, clinics, groups, associations, corporations or institutions have been suspended or have had their provider number(s) deactivated.

Note: Authority cited: Sections 10725, 14043.75 and 14124.5, Welfare and Institutions Code. Reference: Sections 14043.26, 14043.36, 14043.62, 14043.7 and 14123, Welfare and Institutions Code.