Provider Newsletter

For Molina Healthcare of California providers

Second quarter 2025

In this issue

The provider newsletter is available to all network providers serving Molina Healthcare of California members.

Salesforce communications

Several Molina Healthcare departments have transitioned to Salesforce, an AI CRM database for email communication. As a result, you will now receive emails from us via Salesforce. If you have blocked this type of communication, please unblock it to receive important messages such as approval and credentialing decisions. Work with your IT department to unblock these emails by following the steps below:

1. Allow Salesforce email IP addresses to pass through your organization's email system. Below is a list of IP addresses where emails will originate.
2. Verify that your organization's email system supports secure connections (TLS) with the appropriate settings.
3. Ensure your organization's mail server can correctly route emails from Salesforce.
4. Check the authentication protocols on your organization's email server to ensure proper communication.

IP range: 13.108.0.0 – 13.111.255.255	**IP range:** 96.43.144.0 – 96.43.159.255	**IP range:** 182.50.78.0 – 182.50.78.255
Description: Salesforce primary email sending IP range	**Description:** Additional IP range used for email relays and SMTP mail servers	**Description:** IP range associated with specific Salesforce email services

Once these configurations are verified and set up, email communication should function properly between Salesforce and your system.

Molina's utilization management

One of Molina's utilization management (UM) department's goals is to render appropriate UM decisions consistent with objective clinical evidence. To achieve this goal, Molina maintains the following guidelines:

- Our highly trained UM staff evaluates medical information received by our providers against nationally recognized objective- and evidence-based criteria. We also consider individual circumstances (at minimum age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable) and the local delivery system when determining the medical appropriateness of requested health care services.
- Clinical criteria for Molina Healthcare of California (MHC) includes:
  - MCG criteria that are utilized to conduct inpatient review (except when Change Healthcare InterQual® is contractually required)
  - American Society of Addiction Medicine (ASAM) criteria
  - National Comprehensive Cancer Network (NCCN)
  - Hayes Directories
  - Applicable Medicaid guidelines
  - Molina Clinical Policy (MCP) and Molina Clinical Review (MCR) (developed by designated corporate medical affairs staff in conjunction with MHC physicians serving on the Medical Coverage Guidance Committee)
  - UpToDate®
  - Other nationally recognized criteria, including technology assessments and well-controlled studies that meet industry standards, MHC policy, and when appropriate, third-party (outside) board-certified physician reviewers
- MHC ensures all criteria used for UM decision-making are available to practitioners upon request. The clinical policy website, **MolinaClinicalPolicy.com**, provides access to MCP and MCR criteria. Providers can also access the MCG Cite for Care Guideline Transparency tool through our **Availity Essentials provider portal**. To obtain a copy of the UM criteria, call our UM department at **(844) 557-8434**.
- As the requesting practitioner, you will receive written notification of all UM denial decisions. If you need assistance contacting a medical reviewer about a case, please call the UM department at **(844) 557-8434**.

It is important to remember:

- UM decision-making is based only on the appropriateness of care and service and the existence of coverage.
- MHC does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- UM decision-makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.

Molina's utilization management (continued)

- Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, MHC will arrange for a member to obtain a second opinion out of network at no additional cost to the member. MHC provides for a second opinion from a qualified in-network practitioner. Members from all MHC lines of business and programs should refer to their benefit documents (such as schedule of benefits and/or evidence of coverage) for second-opinion coverage benefit details, limitations and cost-share information. If an appropriate practitioner is unavailable in-network, prior authorization (PA) is required to obtain the second opinion of an out-of-network provider. Claims for out-of-network providers without a PA will be denied, unless regulation dictates otherwise. All diagnostic testing, consultations, treatments and/or surgical procedures must be a benefit under the plan and meet all applicable medical necessity criteria to be covered.
- Some of the most common reasons for a delay or denial of a request include:
  - Insufficient or missing clinical information to provide the basis for making the decision
  - Lack of or missing progress notes or illegible documentation

MHC's UM department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call **(844) 557-8434**. You may also fax a question about an UM issue to MHC. The medical director is available to answer more complex medical decision questions and explain medical necessity denials.

MHC offers the ability to quickly and conveniently submit and check PA status through the **Availity provider portal**.

MHC PA fax numbers include:

- **Advanced imaging: (877) 731-7218**
- **Medicaid: (800) 811-4804**
- **Marketplace: (800) 811-4804**
- **MMP physical and behavioral health: (844) 251-1541**
- **Medicare physical and behavioral health: (844) 251-1540**
- **Medicare and MMP inpatient: (844) 834) 2152**
- **Medicare Part D pharmacy: (866) 290-1309**

For information about MHC's formulary PA and the exception process, please refer to the Drug Formulary and Pharmaceutical Procedures article.

MHC's regular business hours are Monday-Friday (excluding holidays), 8 a.m.-5 p.m. Voicemail messages and faxes received after regular business hours will be returned the following business day. MHC has language assistance and TDD/TTY services for members with language barriers, members who are deaf or hard of hearing and those with speech disabilities.

Care management

Molina Healthcare of California (MHC) offers a complex care management program designed to support both you and your patients. This program is available to members facing multiple or complex medical conditions, difficulty adhering to treatment plans, high levels of dependence or those requiring coordinated care across multiple specialties. It also supports individuals dealing with social, psychological or emotional challenges that may complicate their treatment or recovery.

The goal of the MHC Care Management program is to:

- Conduct a thorough needs assessment for the patient and their family or caregivers
- Provide care coordination and intervention services within the patient's benefit coverage
- Empower members to improve their health and daily functioning
- Ensure timely access to medically necessary services at the appropriate level of care
- Create and maintain a comprehensive care plan in collaboration with providers, staff, patients and families to ensure continuity of care

MHC also offers the following care management programs:

- Molina's CA Healthy Beginnings Maternity Program is available for individuals with healthy or high-risk pregnancies. Members are assigned a dedicated nurse (RN) care manager to provide education, care coordination and support to pregnant individuals interested in a healthy pregnancy, delivery and beyond. In addition, MHC utilizes a multidisciplinary care team model in which there is a focused effort in early identification and intervention for maternal mental health and SUD needs. MHC partners with perinatologists and addiction specialists for telehealth visits until the member is connected to in-network behavioral health or county behavioral health providers.
- The MyCare Palliative Care Program provides an extra layer of care and support to members with a prognosis of one year or less and who are not yet ready for hospice. The dedicated team of palliative care case managers work closely with the palliative care provider to deliver home-based palliative care to the member and family and when appropriate and the member is ready, successfully transition to hospice.
- The Transitions of Care (ToC) program provides post-discharge follow-up care to members discharged to the community or home after an acute hospitalization. A Transition of Care coach is assigned to the member and completes the post-discharge assessment to ensure the member has safely and successfully transitioned from the hospital. The ToC coach provides medication review, assists with scheduling follow-up appointments with the member's treating physicians and coordinates the member's care.

If you'd like to learn more, speak with a care manager or refer a patient for evaluation, please call us toll-free at **(833) 234-1258**.

To make a referral, please email or fax the completed referral form to us at:
Email: **MHCCaseManagement@MolinaHealthcare.com**
Fax: **(562) 499-6105**
Case Management Referral Form

Important message – Updating provider information

MHC needs to keep our provider network information current. Up-to-date provider information allows MHC to accurately generate provider directories, process claims and communicate with our provider network. Providers must notify MHC in writing at least 30 days in advance, when possible, of changes, such as:

- Change in practice ownership or Federal Tax ID number
- Practice name change
- Cåhange in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- Primary care providers (PCP) only: If your practice opens or closes to new patients
- When a provider joins or leaves the practice

Changes should be submitted on the **Provider Information Data Form** which is located online.

Send changes to:

- **Los Angeles**
- **Sacramento**
- **San Bernardino**
- **Riverside**
- **San Diego**

Contact your **provider relations representative** if you have questions.

Practitioner credentialing rights: What you need to know

MHC must protect its members by assuring their care is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. As a MHC provider, your responsibility includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

MHC is also responsible to its providers to ensure that the credentialing information it reviews is complete and accurate. As a MHC provider, you have the right to:

- Strict confidentiality of all information submitted during the credentialing process
- Non-discrimination during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what you submit
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, except for references, recommendations or other peer-review protected information
- Correct erroneous information

Practitioner credentialing rights: What you need to know (continued)

- Be informed of the status of your application upon request by calling Provider Services at **(855) 322-4075** or contacting your **provider relations representative**.
- Receive notification of the credentialing decision within 60 days of the committee decision or shorter timeframes as contractually required
- Receive notification of your provider's right to appeal an adverse decision made by the committee
- Be informed of the above rights

Please review our Provider Manual for further details on all your rights as a MHC provider. You may review the Provider Manual on our website at:

- **Medi-Cal Provider Manual**
- **Medicare Provider Manual**
- **Marketplace Provider Manual**

You also can contact your Provider Relations representative at **MolinaHealthcare.com/-/media/E5295860C0774A44AF9CA501EEDE4DC1**.

Drug Formulary and pharmaceutical procedures

For CA Molina Medicaid, the drug formulary is determined by the state and state processes and is called the Covered Drug List (CDL). You can find ore information on Medical-RX and their management of the state-covered drug list can be found **here**. The drug formulary for CA Medicaid can be found on the state **Medi-Cal RX website**.

At MHC, the Marketplace Formularies—sometimes referred to as a Preferred Drug List (PDL)—and pharmacy services procedures are maintained by the National Pharmacy and Therapeutics (P&T) Committee. This committee meets quarterly or more frequently if needed.

The P&T Committee is responsible for developing and updating drug formularies that promote safety, effectiveness and affordability where state regulations allow. The committee objectively reviews new Food and Drug Administration (FDA) approved drugs, drug classes, new clinical indications for existing drugs, new line extensions and generics, new safety information, new clinical guidelines and practice trends that may impact previous formulary placement decisions. Additional committee oversight includes PA, step therapy, quantity limits, generic substitutions, medical exception protocols to allow coverage for non-formulary drugs, other drug utilization management activities that affect access, and drug utilization evaluations and intervention recommendations for MHC health plans. Drug formulary activities are inclusive of prescriber-administered specialty medications as a medical benefit and pharmacy benefit services.

The drug formularies reviewed and approved by the P&T Committee are updated quarterly and include an explanation of quantity limits, age restrictions, therapeutic class preferences and step

Drug Formulary and pharmaceutical procedures (continued)

therapy protocols. These changes and all current documents are also posted on our website at **CA Marketplace**.

Providers may request a formulary exception for coverage of a drug outside of the drug formulary restrictions. A formulary exception should be requested to obtain a drug that is not included on a member's drug formulary or to request that a UM requirement be waived (e.g., step therapy, PA, quantity limit) for a formulary drug.

Select medications on the drug formulary or drugs not listed on the formulary may require PA. PA is a requirement that a prescriber obtains advance approval from Molina before a specific drug is delivered to the member to qualify for payment coverage. The drug formulary/PDL is available online at **CA Marketplace**.

The P&T Committee also promotes member safety. In the event of a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners will be notified by MHC within 30 calendar days of the FDA notification. An expedited process is in place to ensure notification to affected members and prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax, mail and/or phone.

Resources available on Molina's provider website

Featured online at **MolinaHealthcare.com**:

- Clinical practice and preventive health guidelines
- Health management programs
- Quality improvement programs
- Member rights and responsibilities
- Privacy notices
- Provider Manual
- Current formulary
- Cultural competency provider trainings

If you would like to receive any of the information posted on our website in a printed format, please call **(855) 322-4075**.

Translation services

MHC can provide information in our members' primary language. We can arrange for an interpreter to help you speak with our members in almost any language. We also provide written materials in different languages and alternate formats (braille, audio and electronic format). If you need an interpreter or written materials in a language other than English, please contact MHC at **(855) 322-4075**. You can also call **TTD/TTY: 711** if a member has a hearing or speech disability.

Patient safety

Patient safety activities encompass appropriate safety projects and error avoidance for MHC members in collaboration with their PCPs.

The MHC patient safety activities address the following:

- Continued information about safe office practices
- Member education about members taking an active role in reducing the risk of errors in their care
- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between sites of care, such as hospitals and other facilities, to ensure timely and accurate communication
- Distribution of research on proven safe clinical practices

MHC also monitors nationally recognized quality index ratings for facilities from:

- **Leapfrog Quality Index Ratings**
- **The Joint Commission Quality Check®**

Providers can also access the following links for additional information on patient safety:

- **The Leapfrog Group**
- **The Joint Commission**

Hours of operation

MHC requires that providers offer MHC members hours of operation no less than hours offered to commercial members.

Enhancing care for adults 65 and older

Many adults over the age of 65 live with multiple chronic conditions that can significantly impact their daily lives. As this population ages, declines in physical and cognitive function, as well as increased pain, become more common. Proactive and routine assessments can help ensure these individuals receive the comprehensive care they need.

Key components to include in your well-care visits with older adults:

- **Advance care planning** – Begin conversations early about treatment preferences and end-of-life care, including completing advance directives
- **Medication review** – Regularly review all medications, including prescriptions, over-the-counter products and herbal supplements, to avoid adverse interactions and ensure appropriate use
- **Functional status assessment** – Evaluate the patient's ability to perform daily activities and identify any loss of independence or functional decline
- **Pain screening** – Document the presence or absence of pain to guide appropriate management and improve comfort
- **Cognitive screening and assessment** – Early detection of cognitive impairment can lead to timely intervention and better support for patients and caregivers

Providers should include these assessments as part of their routine care for older adults to help identify issues that often go unnoticed—ultimately improving health outcomes and quality of life.

Member rights and responsibilities

MHC wants to inform its providers about some of the rights and responsibilities of MHC members.

MHC members have the right to:

- Receive information about MHC, its services, its practitioners and providers and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Help make decisions about their health care
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions—regardless of cost or benefit coverage
- Voice complaints or appeals about MHC or the care provided
- Make recommendations regarding MHC member rights and responsibilities policy

Molina members have the responsibility to:

- Supply information (to the extent possible) that MHC and its practitioners and providers need to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Keep appointments and be on time (If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.)

You can find the complete Molina Member Rights and Responsibilities Statement on our **website**. Written copies and more information can be obtained by contacting Provider Services at **(855) 322-4075**.

Population health (health education, disease management)

The tools and services described here are educational support for our members. We may change them at any time to meet their needs.

MHC offers programs to help our members and their families manage a diagnosed health condition. As a provider, you also help us identify members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular disease (CVD) management/ congestive heart failure
- Chronic obstructive pulmonary disease (COPD) management
- Depression management

You can find more information about our programs at **here**.

If you have additional question about our programs, please call Provider Services at **(855) 322-4075 (TTY/TDD at 711 Relay)**.

Quality Improvement and Health Equity Transformation Program

MHC Quality Improvement and Health Equity Transformation (QIHET) Program provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The QIHET committee assists the organization in achieving these goals. It is an evolving program that is responsive to the changing needs of the health plan's members and the standards established by the medical community and regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional or state regulators, accrediting organizations and internal MHC thresholds
- Analysis of information and data to identify trends and opportunities and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: claims, UM and/or credentialing
- Confirmation of the quality and adequacy of the provider and health delivery organization network through appropriate contracting and credentialing processes

Quality Improvement and Health Equity Transformation Program (continued)

The QIHET Program promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to MHC members.

The effectiveness of QIHET Program activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multidisciplinary teams—including clinical experts—to analyze service and process improvement opportunities, determine actions for improvement and evaluate results
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the quality work plan quarterly
- Revising interventions based on analysis when indicated
- Evaluating member satisfaction with their experience of care through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey
- Reviewing member satisfaction with their experience with behavioral health services through survey questions and/or evaluation of behavioral health-specific complaints and appeals
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management

MHC would like to help you promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the MHC website, please contact the QI department at **(888) 665-4623**.

If you would like more information about our QI program or initiatives and the progress toward meeting quality goals, you can visit our **website** and access the Health Resources area on our provider website pages. If you would like to request a paper copy of our documents, please call the QI department at **(888) 665-4623**.

Standards for medical record documentation

MHC has established standards for medical record documentation to help assure the highest quality of care for our members. Medical record standards promote quality care through communication, coordination and continuity of care and efficient and effective treatment.

MHC medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening
- Vaccinations and/or injections

For more information, please call the QI department at **(888) 665-4623**.

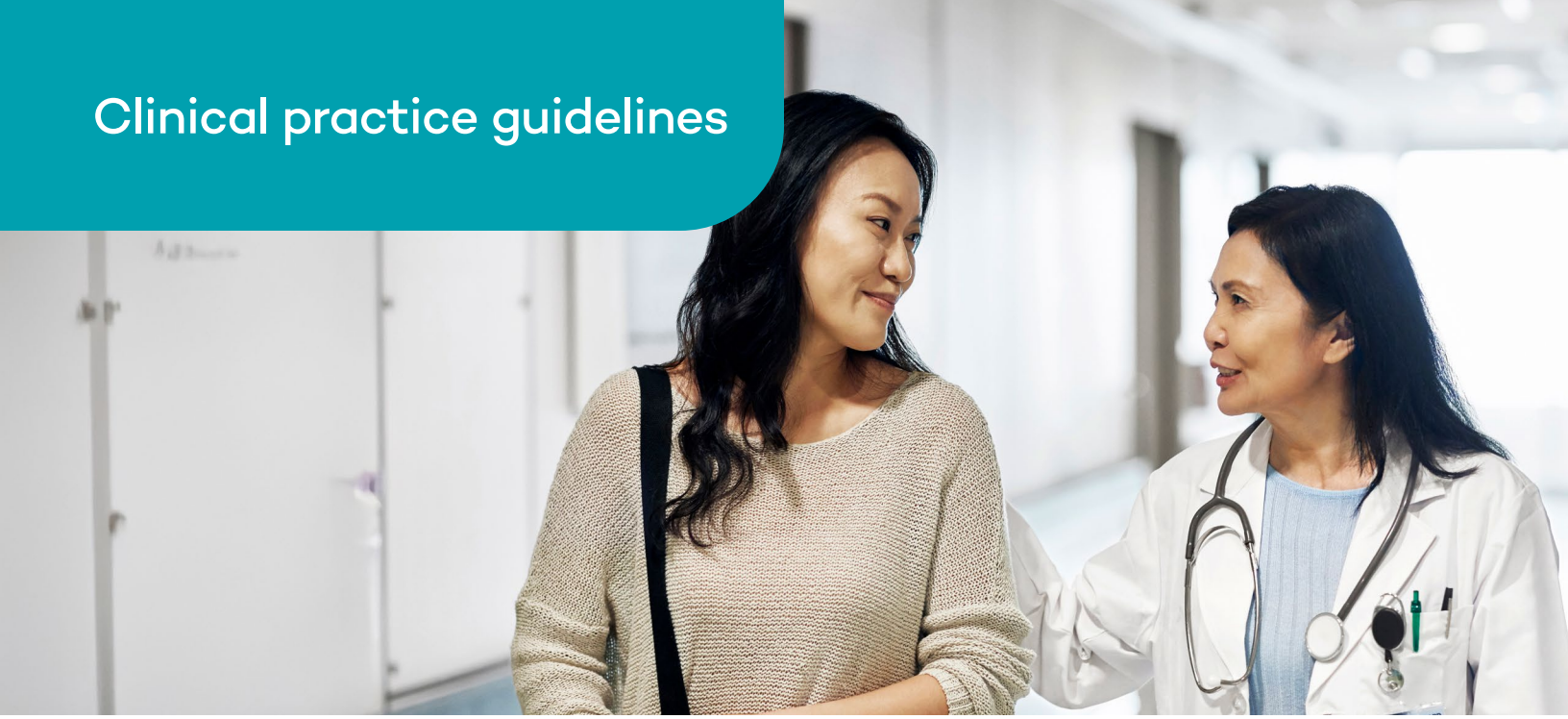
Preventive health guidelines

Preventive health guidelines can benefit providers and their patients. Guidelines are based on scientific evidence, a review of the medical literature or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the member's needs.

You can view all guidelines by accessing the **Health Resources section** on our provider web pages. To request printed copies of preventive health guidelines, please contact Provider Services at **(855) 322-4075**.

Clinical practice guidelines



Clinical practice guidelines are based on scientific evidence and a review of the medical literature or appropriately established authority.All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The care recommendations are suggested as guides for making clinical decisions. Providers and our members must work together to develop individual treatment plans that are tailored to the member's specific needs and circumstances.

MHC has adopted the following Clinical Practice and Behavioral Health Guidelines, which include but are not limited to:

- Acute stress and post-traumatic stress disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention deficit hyperactivity disorder (ADHD)
- Autism
- Bipolar disorder
- Children with special health care needs
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure in adults
- Homelessness - special health care needs
- Hypertension
- Obesity
- Opioid management
- Perinatal care
- Pregnancy management
- Schizophrenia
- Sickle cell disease
- Substance abuse treatment
- Suicide risk
- Trauma-informed primary care

You can also view all guidelines in the **Health Resources section** on the provider web pages. To request a copy of any guidelines, please contact Provider Services at **(855) 322-4075**.

Advance directives

Providers can assist MHC members in preparing an advance directive. Anyone 18 or older can have an advance directive, including a living will document and a durable power of attorney.

A living will is written instruction explaining the wishes of a MHC member regarding health care in the case of a terminal illness or any medical procedures that can prolong life. A durable power of attorney names a person to make decisions for our members if they cannot.

The following links provide free forms and information to help create an advance directive:

- **Caringinfo**
- **National Library of Medicine**

Members will need two witnesses for the living will and valid notarization for a durable power of attorney.

An advance directive must be honored to the fullest extent permitted under law. Providers should discuss advance directives and provide appropriate medical advice if the member desires guidance or assistance, including any objections they may have to a directive prior to service whenever possible. Providers cannot refuse treatment or otherwise discriminate against members because they completed an advance directive. Members have the right to file a complaint if they are dissatisfied with the handling of an advance directive and/or if there is a failure to comply with advance directive instructions.

Providers should have materials on advance directives for members to review. They should also put a copy of a completed advance directive form in a prominent section of the medical record. The medical record should also document if a member chooses not to execute an advance directive. Providers should inform members that advance care planning is a part of good health care.

Behavioral health

PCPs provide outpatient behavioral health services within the scope of their practice and are responsible for coordinating members' physical and behavioral health care.

Behavioral health services are a direct access benefit and are available with no required referrals; however, PCPs are responsible for assisting in coordinating access and treatment, if needed. If you or the member need assistance with obtaining behavioral health services, please contact Member Services at **(888) 665-4621**.

Our 24-hour Nurse Advice Line is also available to members 24 hours a day, 7 days a week, 365 days per year for mental health or substance use needs. The services received will be confidential.

Providers may refer to the **MHC Behavioral Health Toolkit** for providers online for additional clinical guidance, recommendations and training/education opportunities related to behavioral health conditions.

Care coordination and transitions

Coordination of care during planned and unplanned transitions for MHC members

MHC is dedicated to providing quality care for our members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina member is discharged from a hospital. By working together with providers, MHC makes a special effort to coordinate care during transitions to avoid potential adverse outcomes.

MHC has resources to assist you in easing the challenge of coordinating care. Our staff, including nurses, can work with all parties to ensure appropriate care.

To appropriately coordinate care, Molina will need the following information in writing from the facility within one business day of the transition from one setting to another:

- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information should be faxed to MHC at:

- UM department: **(866) 553-9263**
- Member Services: **(800) 811-4804 (TTY/TDD: 711)**

Initial Health Appointment (IHA) for children, adults and seniors

Effective January 1, 2023, the completion of the IHEBA/SHA is no longer a required component of the Initial Health Appointment (IHA).

In accordance with regulatory requirements and increased focus from the California Department of Health Care Services, **new members must receive a comprehensive IHA within the first 120 days of enrollment** with Molina or within periodicity timelines established by the American Academy of Pediatrics for ages two and younger, whichever is less.

A compliant IHA consists of:

- **Comprehensive history** to assess and diagnose acute and chronic conditions, which include, but are not limited to, the following:
  - **History of present illness**
  - **Past medical history (physical and mental health)**
  - **Social history**
  - **Review of organ systems** (physical and mental systems)
  - **Identification of risks**
  - **Assessment of need for preventive screens or services**
  - **Health education**
  - Diagnosis and plan for treatment of any diseases
- **Comprehensive physical and mental exam**
  - The exam must be sufficient to assess and diagnose acute and chronic conditions and develop a plan of care. The plan of care must include follow-up activities and all exams that the member received.
- **Dental exam** in initial health assessment (all ages)
- **Dental referral** (for age 3 to < 21 only)

For billing of services associated with the completion of the comprehensive IHA, please note the following CPT codes:

Medi-Cal member population	CPT billing codes	ICD-10 reporting codes
Preventive Visit, New Patient	99381 - 99387	No restriction
Preventive Visit, Established Patient	99391 - 99397	No restriction
Office Visit, New Patient	99204 - 99205	No restriction
Office Visit, Established Patient	99215	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z01.401, Z01.419, Z00.9, Z02.1, Z02.3, Z02.89