WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 1.3. Provider Enrollment, Application, and Participation [14043 - 14045] *(Heading of Article 1.3 amended by Stats. 2003, Ch. 601, Sec. 1.)*

14043. In order to ensure the proper and efficient administration of the Medi-Cal program, every applicant, as defined in subdivision (b) of Section 14043.1, and every provider, as defined in subdivision (o) of Section 14043.1, shall be subject to the requirements of this article.

(Amended by Stats. 2010, Ch. 192, Sec. 1. (AB 1783) Effective January 1, 2011. Note: Sections 14040 to 14042 are located following Section 14029.91, at the end of Article 1.)

14043.1. As used in this article:

(a) “Abuse” means either of the following:

(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs, the Medi-Cal program, another state’s Medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state.

(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs, the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(b) “Applicant” means an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the department for enrollment as a provider in the Medi-Cal program.

(c) “Application or application package” means a completed and signed application form, signed under penalty of perjury or notarized pursuant to Section 14043.25, a disclosure statement, a provider agreement, and all attachments or changes in the form, statement, or agreement.

(d) “Appropriate volume of business” means a volume that is consistent with the information provided in the application and any supplemental information provided by the applicant or provider, and is of a quality and type that would reasonably be expected based upon the size and type of business operated by the applicant or provider.

(e) “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.

(f) “Convicted” means any of the following:

(1) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a posttrial motion, an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(2) A federal, state, or local court has made a finding of guilt against an individual or entity.

(3) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(g) “Debt due and owing” means 60 days have passed since a notice or demand for repayment of an overpayment or another amount resulting from an audit or examination, for a penalty assessment, or for another amount due to the department was sent to the provider, regardless of whether the provider is an institutional provider or a noninstitutional provider and regardless of whether an appeal is pending.

(h) “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.

(i) “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(j) “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.

(k) “Not currently enrolled at the location for which the application is submitted” means either of the following:

(1) The provider is changing location and moving to a different location than that for which the provider was issued a provider number.

(2) The provider is adding a business address.

(l) (1) “Individual dentist practice” means a dentist licensed by the Dental Board of California enrolled or enrolling in Medi-Cal as an individual provider who is a sole proprietor of his or her practice or is a corporation owned solely by the individual dentist and the only dentist practitioner is the owner. An individual dentist practice may include nondentist allied dental health professionals employed and supervised by the dentist.

(2) “Individual physician practice” means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include nonphysician medical practitioners employed and supervised by the physician.

(m) “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.

(n) “Professionally recognized standards of health care” means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This subdivision shall not be construed to mean that all other treatments meet professionally recognized standards of care.

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

(p) “Resolution of an investigation for fraud or abuse” means there is no documentation to indicate either that a charge or accusation has been filed against the provider and either (1) the investigation has not been active at any time during the previous 12 months or (2) the department has made a documented good faith effort and has been unable, for a period of 12 months, to contact an investigator or responsible representative of any agency investigating the provider.

(q) “Unnecessary or substandard items or services” means those that are either of the following:

(1) Substantially in excess of the provider’s usual charges or costs for the items or services.

(2) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, Medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient’s needs, or of a quality that fails to meet professionally recognized standards of health care. The department’s determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(A) The professional review organization for the area served by the individual or entity.

(B) State or local licensing or certification authorities.

(C) Fiscal agents or contractors or private insurance companies.

(D) State or local professional societies.

(E) Any other sources deemed appropriate by the department.

(Amended by Stats. 2015, Ch. 271, Sec. 1. (SB 299) Effective September 4, 2015.)

14043.15. (a) The department may adopt regulations for certification of each applicant and each provider in the Medi-Cal program. No certification shall be required for natural persons licensed or certificated under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

(b) (1) An applicant or provider who is a natural person, and is licensed or certificated pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, as defined in subdivision (b) of Section 13401 of the Corporations Code, shall comply with Section 14043.26 and shall be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package submitted and approved pursuant to Section 14043.26, notwithstanding that the applicant or provider meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

(2) A provider enrolled in the Medi-Cal program pursuant to paragraph (1), who has disclosed in the application package for enrollment that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one, or at more than one, health facility, as defined in Section 1250 of the Health and Safety Code, or clinic, as defined in Section 1204 of the Health and Safety Code, or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code, or residence of the provider's patient, or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence, or physician and surgeon's office location and may utilize the business addresses listed on the application for enrollment pursuant to paragraph (1) to claim reimbursement from the Medi-Cal program for services rendered by the provider to Medi-Cal beneficiaries at all of those health facilities, clinics, medical therapy units, residences, or physician offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering, ordering, referring, and prescribing provider, where applicable.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (l), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if all of the following conditions are met:

(1) The applicant or provider is one of the following:

(A) An intermittent site that qualifies as exempt from clinic licensure under subdivision (h) of Section 1206 of the Health and Safety Code.

(B) An affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and qualifies as exempt from clinic licensure under subdivision (h) of Section 1206 of the Health and Safety Code.

(2) The applicant or provider is operated by, and all staffing, protocols, equipment, supplies, and billing services are provided, directly or indirectly, by, one of the following:

(A) A licensed primary care clinic.

(B) A clinic exempt from licensure pursuant to subdivision (b) of Section 1206 of the Health and Safety Code.

(3) The licensed primary care clinic or clinic exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.

(f) A primary care clinic with (1) an additional physical plant added to its primary care clinic license under a consolidated license pursuant to subdivision (d) of Section 1212 of the Health and Safety Code, or (2) a physical plant that was added to an existing primary care clinic license by the State Department of Public Health, prior to January 1, 2017, whether by a regional district office or the centralized application unit, need not separately enroll the additional physical plant as a separate provider, and need not comply with Section 14043.26 if the primary care clinic has notified the department of its additional physical plant.

(g) Notwithstanding any other law and to the extent permitted by federal law, an applicant or provider that meets the requirements to qualify as a mobile optometric office pursuant to Section 3070.2 of the Business and Professions Code and Section 14043.26 may be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies.

(1) An applicant or provider to which Section 3070.2 of the Business and Professions Code applies shall demonstrate its compliance by providing proof of its nonprofit or charitable organization status pursuant to Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code and a statement that it shall not accept payment for services other than those provided to Medi-Cal beneficiaries, even if the State Board of Optometry has not yet issued final regulations as required by Section 3070.2 of the Business and Professions Code or issued any registrations at the time of enrollment.

(2) A mobile optometric office shall use the address of the owner and operator of the mobile optometric office as registered with the State Board of Optometry for its place of business address and shall not be required to comply with Section 51000.60 of Title 22 of the California Code of Regulations.

(3) To the extent federal financial participation is available, a mobile optometric office shall be permitted to bill the Medi-Cal program for the professional optometry services provided by licensed optometrists. The licensed optometrists providing service at a mobile optometric office shall use the address of the owner and operator of the mobile optometric office as registered with the State Board of Optometry for its place of business address and shall not be required to comply with Section 51000.60 of Title 22 of the California Code of Regulations.

(Amended by Stats. 2024, Ch. 448, Sec. 2. (SB 819) Effective January 1, 2025.)

14043.17. (a) Notwithstanding any other law, within 30 calendar days of receiving confirmation of certification for enrollment as a Medi-Cal provider for an affiliate primary care clinic that is licensed pursuant to Section 1218.1 of the Health and Safety Code, the department shall provide written notice to the applicant informing the applicant that its Medi-Cal enrollment is approved.

(b) The department shall enroll the affiliate primary care clinic retroactive to the date of certification.

(c) This section shall not be construed to limit the department's authority pursuant to Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(Added by Stats. 2014, Ch. 356, Sec. 1. (AB 2051) Effective January 1, 2015.)

14043.2. (a) Whether or not regulations for certification are adopted under Section 14043.15, in order to be enrolled as a provider, or for enrollment as a provider to continue, an applicant or provider may be required to sign a provider agreement and shall disclose all information as required in federal Medicaid regulations and any other information required by the department. Applicants, providers, and persons with an ownership or control interest, as defined in federal Medicaid regulations, shall submit their date of birth and their social security number or numbers to the department, to the full extent allowed under federal law. Corporations with an ownership or control interest, as defined in federal Medicaid regulations, shall submit their taxpayer identification number and all business address locations and post office box addresses. The director may designate the form of a provider agreement by provider type. Failure to disclose the required information, or the disclosure of false information, shall result in denial of the application for enrollment or shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number or numbers, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's number or numbers, including all business addresses used by the provider, and the effective date thereof. Notwithstanding Section 100171 of the Health

and Safety Code and Section 14123, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

(Amended by Stats. 2012, Ch. 797, Sec. 6. (SB 1529) Effective January 1, 2013.)

14043.25. (a) The application form for enrollment, the provider agreement, and all attachments or changes to either, shall be signed under penalty of perjury.

(b) The department may require that the application form for enrollment, the provider agreement, and all attachments or changes to either, submitted by an applicant or provider licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, be notarized.

(c) Application forms for enrollment, provider agreements, and all attachments or changes to either, submitted by an applicant or provider not subject to subdivision (b) shall be notarized. This subdivision shall not apply with respect to providers under the In-Home Supportive Services program or any providers that choose to enroll electronically.

(d) The department shall collect an application fee for enrollment, including continued enrollment or enrollment at a new location or a change in location. The application fee shall not be collected from individual physicians or nonphysician practitioners, from providers that are enrolled in Medicare or another state's Medicaid program or Children's Health Insurance Program, from providers that submit proof that they have paid the applicable fee to a Medicare contractor or to another state's Medicaid program, or pursuant to an exemption or waiver pursuant to federal law. The application fee collected shall be in the amount calculated by the federal Centers for Medicare and Medicaid Services in effect for the calendar year during which the application for enrollment is received by the department.

(Amended by Stats. 2015, Ch. 271, Sec. 3. (SB 299) Effective September 4, 2015.)

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) A physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a dentist licensed by the Dental Board of California, practicing as an individual physician practice or as an individual dentist practice, as defined in Section 14043.1, who is enrolled and in good standing in the Medi-Cal program, and who is changing locations of that individual physician practice or individual dentist practice within the same county, shall be eligible to continue enrollment at the new location by filing a change of location form to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. Filing this form shall be in lieu of submitting a complete application package pursuant to subdivision (a).

(c) (1) Except as provided in paragraph (2), within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(2) Within 15 days after receiving 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, or a change of location form pursuant to subdivision (b), the department shall provide written notice that the application package or the change of location form has been received.

(d) (1) If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. 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 the criteria listed in paragraph (2). 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.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall enroll the applicant or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this subdivision, after submission and review of a short form application:

(A) The applicant's or provider's practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in subdivisions (a) and (b) of Section 1250 of the Health and Safety Code.

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

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

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(E) For failing to submit fingerprints as required by federal Medicaid regulations.

(F) For failing to pay an application fee as required by federal Medicaid regulations.

(5) The application package is withdrawn by request of the applicant or provider and the department's review is canceled pursuant to subdivision (n).

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California, or from the date of the notice to that physician or physician group that does not qualify as a preferred provider under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), (4), or (5) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

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

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(D) The application package is withdrawn by request of the applicant or provider and the department's review is canceled pursuant to subdivision (n).

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a currently enrolled provider as defined in Section 14043.1, including providers applying for continued enrollment, the failure may make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

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

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a currently enrolled provider as defined in Section 14043.1, including providers applying for continued enrollment, the failure may make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, 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 was approved, unless 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 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.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(l) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) (1) Except as provided in paragraph (2), an applicant or provider may request to withdraw an application package submitted pursuant to this section at any time, at which point the department's review shall be canceled.

(2) The department's review shall not be canceled if, at the time the applicant or provider requests to withdraw the application package, the department has already initiated its review under Section 14043.37, 14043.4, or 14043.7.

(Amended by Stats. 2014, Ch. 442, Sec. 22. (SB 1465) Effective September 18, 2014.)

14043.27. (a) If an applicant or provider is granted provisional provider status or preferred provisional provider status pursuant to Section 14043.26 and, if at any time during the provisional provider status period or preferred provisional provider status period, the department conducts any announced or unannounced visits or any additional inspections or reviews pursuant to this chapter or Chapter 8 (commencing with Section 14200), or the regulations adopted thereunder, or pursuant to Section 100185.5 of the Health and Safety Code, and discovers or otherwise determines the existence of any ground to deactivate the provider's number and business addresses or suspend the provider from the Medi-Cal program pursuant to this chapter or Chapter 8 (commencing with Section 14200), or the regulations adopted thereunder, or pursuant to Section 100185.5 of the Health and Safety Code, or if any of

the circumstances listed in subdivision (c) occur, the department shall terminate the provisional provider status or preferred provisional provider status of the provider, regardless of whether the period of time for which the provisional provider status or preferred provisional provider status was granted under Section 14043.26 has elapsed.

(b) Termination of provisional provider status or preferred provisional provider status shall include deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program and removal of the provider from enrollment in the Medi-Cal program, except where the termination is based upon a ground related solely to a specific location for which provisional provider status was granted. Termination of provisional provider status based upon grounds related solely to a specific location may include failure to have an established place of business, failure to possess the business or zoning permits or other approvals necessary to operate a business, or failure to possess the appropriate licenses, permits, or certificates necessary for the provider of service category or subcategory identified by the provider in its application package. Where the grounds relate solely to a specific location, the termination of provisional provider status shall include only deactivation of the specific locations that the grounds apply to and shall include removal of the provider from enrollment in the Medi-Cal program only if, after deactivation of the specific locations, the provider does not have any business address that is not deactivated.

(c) The following circumstances are grounds for termination of provisional provider status or preferred provisional provider status:

(1) The provider, persons with an ownership or control interest in the provider, or persons who are directors, officers, or managing employees of the provider have 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 health care item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or have been found liable for fraud or abuse in any civil proceeding, or have entered into a settlement in lieu of conviction for fraud or abuse in any government program within 10 years of the date of the application package.

(2) There is a material discrepancy in the information provided to the department, or with the requirements to be enrolled, that is discovered after provisional provider status or preferred provisional provider status has been granted and that cannot be corrected because the discrepancy occurred in the past.

(3) The provider has provided material information that was false or misleading at the time it was provided.

(4) The provider failed to have an established place of business at the business address for which the application package was submitted at the time of any onsite inspection, announced or unannounced visit, or any additional inspection or review conducted pursuant to this article or a statute or regulation governing the Medi-Cal program, unless 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 at locations other than the 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.

(5) The provider meets the definition of a clinic under Section 1200 of the Health and Safety Code, but is not licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and fails to meet the requirements to qualify for at least one exemption pursuant to Section 1206 or 1206.1 of the Health and Safety Code.

(6) The provider performs clinical laboratory tests or examinations, but it or its personnel do not meet CLIA, and the regulations adopted thereunder, and the state clinical laboratory law, do not possess valid CLIA certificates and clinical laboratory registrations or licenses pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code, or are not exempt from licensure as a clinical laboratory under Section 1241 of the Business and Professions Code.

(7) The provider fails to possess either of the following:

(A) The appropriate licenses, permits, certificates, or other approvals needed to practice the profession or occupation, or provide the services, goods, supplies, or merchandise the provider identified in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted and for the location for which the application was submitted.

(B) The business or zoning permits or other approvals necessary to operate a business at the location identified in its application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(8) The provider, or if the provider is a clinic, group, partnership, corporation, or other association, any officer, director, or shareholder with a 10 percent or greater interest in that organization, commits two or more violations of the federal or state statutes or regulations governing the Medi-Cal program, and the violations demonstrate a pattern or practice of fraud, abuse, or provision of unnecessary or substandard medical services.

(9) The provider commits any violation of a federal or state statute or regulation governing the Medi-Cal program or of a statute or regulation governing the provider's profession or occupation and the violation represents a threat of immediate jeopardy or significant harm to any Medi-Cal beneficiary or to the public welfare.

(10) The provider submits claims for payment that subject a provider to suspension under Section 14043.61.

(11) The provider submits claims for payment for services, goods, supplies, or merchandise rendered at a location other than the business address or addresses listed on the application for enrollment, unless 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 at locations other than the 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 was granted.

(12) The provider has not paid its fine, or has a debt 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 or state health care program, and has not made satisfactory arrangements to fulfill the obligation or otherwise been excused by legal process from fulfilling the obligation.

(d) If, during a provisional provider status period or a preferred provisional provider status period, the department conducts any announced or unannounced visits or any additional inspections or reviews pursuant to this chapter or Chapter 8 (commencing with Section 14200), or the regulations adopted thereunder, and commences an investigation for fraud or abuse, or discovers or otherwise determines that the provider is under investigation for fraud or abuse by any other state, local, or federal government law enforcement agency, the provider shall be subject to termination of provisional provider status or preferred provisional provider status, regardless of whether the period of time for which the provisional provider status or preferred provisional provider status was granted under Section 14043.26 has elapsed.

(e) A provider whose provisional provider status or preferred provisional provider status has been terminated pursuant to this section may appeal the termination in accordance with Section 14043.65.

(f) Any department-recovered fine or debt due and owing, including overpayments, that are subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with interest paid in accordance with subdivision (e) of Section 14171 and Section 14172.5.

(Amended by Stats. 2007, Ch. 188, Sec. 41. Effective August 24, 2007.)

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred provisional provider status is terminated under Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years from the date the application package is denied or the provisional provider status is terminated, except as provided otherwise in paragraph (2) of subdivision (h), or paragraph (2) of subdivision (i), of Section 14043.26 and as set forth in this section.

(2) If the application is denied under paragraph (2) of subdivision (h) of Section 14043.26 because the applicant failed to resubmit an incomplete application package or is denied under paragraph (2) of subdivision (i) of Section 14043.26 because the applicant failed to remediate discrepancies, the applicant may resubmit an application in accordance with paragraph (2) of subdivision (h) or paragraph (2) of subdivision (i), respectively.

(3) If the denial of the application package is based upon a conviction for any offense or for any act included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon a conviction for any offense or for any act included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of 10 years from the date the application package is denied or the provisional provider status or preferred provisional provider status is terminated.

(4) If the denial of the application package is based upon two or more convictions for any offense or for any two or more acts included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon two or more convictions for any offense or for any two acts included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be permanently barred from enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors.

(5) The prohibition in paragraph (1) against reapplying for three years shall not apply if the denial of the application or termination of provisional provider status or preferred provisional provider status is based upon any of the following:

(A) The grounds provided for in paragraph (4), or subparagraph (B) of paragraph (7), of subdivision (c) of Section 14043.27.

(B) The grounds provided for in subdivision (d) of Section 14043.27, if the investigation is closed without any adverse action being taken.

(C) The grounds provided for in paragraph (6) of subdivision (c) of Section 14043.27. However, the department may deny reimbursement for claims submitted while the provider was noncompliant with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) (42 U.S.C. Sec. 263a et seq.).

(D) The grounds provided for in subdivision (b) of Section 14043.36 for being terminated or excluded under Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(b) (1) If an application package is denied under subparagraph (A), (B), (D), or (E) of paragraph (4) of subdivision (f) of Section 14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (h), or subparagraph (B) of paragraph (2) of subdivision (i), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

(Amended by Stats. 2015, Ch. 271, Sec. 4. (SB 299) Effective September 4, 2015.)

14043.29. (a) If, at the end of the period for which provisional provider status or preferred provisional provider status was granted under Section 14043.26, all of the following conditions are met, the provisional status shall cease and the provider shall be enrolled in the Medi-Cal program without designation as a provisional provider:

(1) The provider has demonstrated an appropriate volume of business.

(2) The provisional provider status or preferred provisional provider status has not been terminated or if it has been terminated, the act of termination was rescinded.

(3) The provider continues to meet the standards for enrollment in the Medi-Cal program as set forth in this article and Section 51000 and following of Title 22 of the California Code of Regulations.

(b) (1) An applicant or a provider who applied for enrollment or continued enrollment in the Medi-Cal program, prior to May 1, 2003, and for whom the application has not been approved or denied, or who has not received a notice on or before January 1, 2004, that the department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, shall be granted provisional provider status effective on January 1, 2004. Applications from applicants or providers who have been so noticed prior to January 1, 2004, shall be processed in accordance with subdivision (h) of Section 14043.26.

(2) Applications from applicants or providers that have been received by the department after May 1, 2003, but prior to January 1, 2004, shall be processed in accordance with Section 14043.26, except that these application packages shall be deemed to have been received by the department on January 1, 2004.

(Amended by Stats. 2009, Ch. 298, Sec. 27. (AB 1540) Effective January 1, 2010.)

14043.3. A provider shall be required to reimburse those Medi-Cal funds received during any period for which material information was not reported, or reported falsely, to the department.

(Added by Stats. 1999, Ch. 146, Sec. 37. Effective July 22, 1999.)

14043.34. (a) As a condition of a pharmacy's participation in the Medi-Cal program, the pharmacy shall have in stock and regularly dispense prescription drugs.

(b) For purposes of this section, “prescription drugs” means any drug unsafe for self use by a person, and includes either of the following:

(1) Any drug that bears the legend: “Rx Only” or “Caution: federal law prohibits dispensing without prescription” or words of similar import.

(2) Any other drug that by federal or state law can be lawfully dispensed by the prescription of a licensed physician and surgeon.

(Added by Stats. 2000, Ch. 322, Sec. 18. Effective January 1, 2001.)

14043.341. (a) Each provider that dispenses, as defined in Section 4024 of the Business and Professions Code, or that furnishes, as defined in Section 4026 of the Business and Professions Code, a controlled drug, a dangerous drug, or a dangerous device to a Medi-Cal beneficiary, or a drug or device requiring a written order or prescription for the drug or device to be covered under the Medi-Cal program, or who obtains a biological specimen from a Medi-Cal beneficiary for the performance of a clinical laboratory test or examination shall maintain a record of the signature of the person receiving the drug or device or from whom a biological specimen was obtained; the printed name of the recipient or person from whom the biological specimen was obtained; the date signed; for a drug or device, the prescription number or a description of the item or items dispensed or furnished; and if the recipient is not the beneficiary for whom the drug or device was ordered or prescribed or from whom a biological specimen was obtained, a notation of the recipient’s relationship to that beneficiary. The signature and printed name of the person from whom a biological specimen is obtained on the requisition provided to the clinical laboratory for performance of the test or examination for which the specimen was obtained shall be sufficient to comply with this section if a copy of the signed requisition is kept by the provider obtaining the biological specimen. Furthermore, no signature is required under this section where the biological specimen is obtained for the purpose of anatomical pathology examinations performed during the inpatient or outpatient surgery if a notation of the performance of the anatomical pathology examination appears in the medical record.

(b) For purposes of this section:

(1) “Biological specimen” shall have the same meaning as in Section 1206 of the Business and Professions Code.

(2) “Clinical laboratory test or examination” shall have the same meaning as in Section 1206 of the Business and Professions Code.

(3) “Controlled substance” shall mean any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

(4) “Dangerous drug” or “dangerous device” has the same meaning as in Section 4022 of the Business and Professions Code.

(5) “Drug or device” means:

(A) “Drug,” as defined in Section 4025 of the Business and Professions Code.

(B) “Device,” as defined in Section 4023 of the Business and Professions Code.

(C) Pharmaceuticals, medical equipment, medical supplies, orthotics and prosthetics appliances, and other product-like supplies or equipment.

(c) Nothing in this section shall require a provider who dispenses or furnishes a complimentary sample of a dangerous drug to maintain the signature of the person receiving that drug, provided no charge is made to the patient, and an appropriate record is entered in the patient’s chart.

(d) If the dispensing or furnishing of a drug or device occurs on a periodic basis within an established provider-patient relationship, the signature shall only be required upon the initial dispensing or furnishing of the drug, so long as an appropriate record of each dispensing or furnishing is entered in the patient’s chart.

(e) If the obtaining of a biological specimen is required in order that a test or examination occur on a periodic basis within an established provider-patient relationship, the signature shall only be required upon obtaining the biological specimen necessary for the initial test or examination so long as an appropriate record of each test or examination is entered in the patient’s chart.

(f) The requirement of this section to obtain a signature shall not apply to a licensed pharmacy or clinical laboratory that is owned and operated by a nonprofit health care service plan that has at least 3,500,000 enrollees or that is owned and operated by a nonprofit hospital corporation that has a mutually exclusive contract with a nonprofit health care service plan that has at least 3,500,000 enrollees, or to a licensed provider who practices within a physician organization that meets either of the requirements set forth in paragraph (2) of subdivision (g) of Section 1375.4 of the Health and Safety Code.

(Added by Stats. 2003, Ch. 601, Sec. 8. Effective January 1, 2004.)

14043.35. Sections 14043.2, 14043.25, and 14043.3 shall not limit the authority granted the director and the rights granted providers in Section 14123. Action taken under the authority granted in Section 14123 shall be taken in accordance with that section.

(Added by Stats. 1999, Ch. 146, Sec. 37. Effective July 22, 1999.)

14043.36. (a) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) If it is discovered that a provider has been terminated under Medicare or under the Medicaid program or Children's Health Insurance Program in any other state, the provider shall not be enrolled in, or shall be subject to termination from, the Medi-Cal program, which shall include deactivation of the provider's enrolled numbers and all business addresses used to obtain reimbursement from the Medi-Cal program.

(c) The director shall notify in writing the provider of the temporary suspension and deactivation of the provider's number, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

(d) A temporary suspension may be lifted when a resolution of an investigation for fraud or abuse occurs.

(Amended by Stats. 2015, Ch. 271, Sec. 5. (SB 299) Effective September 4, 2015.)

14043.37. The department may complete a background check on applicants for the purpose of verifying the accuracy of the information provided to the department for purposes of enrolling in the Medi-Cal program and in order to prevent fraud and abuse. The background check may include, but is not limited to, the following:

(a) Onsite inspection prior to enrollment.

(b) Review of business records.

(c) Data searches.

(Amended by Stats. 2000, Ch. 322, Sec. 20. Effective January 1, 2001.)

14043.38. (a) Provider types are designated as "limited," "moderate," or "high" categorical risk by the federal government in Section 424.518 of Title 42 of the Code of Federal Regulations. The department shall, at minimum, utilize the federal regulations in determining a provider's or applicant's categorical risk.

(b) In accordance with Section 455.450 of Title 42 of the Code of Federal Regulations, the department shall designate a provider or applicant as a "high" categorical risk if any of the following occur:

(1) The department imposes a payment suspension based on a credible allegation of fraud, waste, or abuse.

(2) The provider or applicant has an existing Medicaid overpayment based on fraud, waste, or abuse.

(3) The provider or applicant has been excluded by the federal Office of the Inspector General or another state's Medicaid program within the previous 10 years.

(4) The department or the federal Centers for Medicare and Medicaid Services lifted a temporary moratorium within the previous six months for the particular provider type submitting the application, the applicant would have been prevented from enrolling based on that previous moratorium, and the applicant applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

(c) If the department designates a provider or applicant as a "high" categorical risk, the department or its designee shall do both of the following:

(1) Conduct a criminal background check of the following persons:

(A) The provider or applicant. If the provider or applicant is a nonprofit Drug Medi-Cal provider or applicant, the officers and executive director of the provider or applicant.

(B) Any person with a 5-percent or greater direct or indirect ownership interest in the provider or applicant.

(2) Require the following persons to submit a set of fingerprints within 30 days of the department's request, in a manner determined by the department:

(A) The provider or applicant. If the provider or applicant is a nonprofit Drug Medi-Cal provider or applicant, the officers and executive director of the provider or applicant.

(B) Any person with a 5-percent or greater direct or indirect ownership interest in the provider or applicant.

(d) (1) The department shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of Medi-Cal providers or applicants determined to be a "high" categorical risk pursuant to subdivision (a), and any person with a 5-percent or greater direct or indirect ownership interest in those providers and applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this section. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the department.

(3) The Department of Justice shall provide a state or federal level response to the department pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The department shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1).

(5) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section. That fee shall be paid by the subject of the criminal background check.

(e) For persons subject to the requirements of subdivision (a) of Section 15660, the procedure for obtaining and submitting fingerprints and notification by the Department of Justice of criminal record information set forth in subdivision (c) of Section 15660 shall apply instead of the procedure set forth in subdivision (d).

(Amended by Stats. 2015, Ch. 271, Sec. 6. (SB 299) Effective September 4, 2015.)

14043.4. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure of a provider to remediate discrepancies as prescribed by the director may result in denial of the application for enrollment. The department may deactivate all of the provider's business addresses if the department determines that the discrepancies are material to the provider's continued enrollment and the provider's compliance with program requirements at the additional business addresses.

(Amended by Stats. 2015, Ch. 271, Sec. 7. (SB 299) Effective September 4, 2015.)

14043.45. (a) Notwithstanding whether a National Provider Identification (NPI) number is required by the rules issued by the Centers for Medicare and Medicaid Services implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the department may require that an applicant or provider submit an NPI number.

(b) For transactions not specifically identified as covered transactions under the HIPAA NPI rules, the department may require that a provider use a National Provider Identification number on those transactions, or the department may issue the provider a unique identification number or numbers that shall be used on all transactions.

(c) Notwithstanding any other provisions of law, the department may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific this statute, including taking all of the following actions:

(1) Notifying provider representatives of the proposed action or change. The notice shall occur at least 10 business days prior to the meeting provided for in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the action or change.

(3) Allowing for written input regarding the action or change.

(4) Providing at least 30 days' advance notice of the effective date of the action or change.

(d) This section shall apply to any health care program administered by the department or its agents or contractors.

(Repealed and added by Stats. 2007, Ch. 188, Sec. 45. Effective August 24, 2007.)

14043.46. (a) Notwithstanding any other provision of law, on the effective date of the act adding this section, the department may implement a one-year moratorium on the certification and enrollment into the Medi-Cal program of new adult day health care centers on a statewide basis or within a geographic area.

(b) The moratorium shall not apply to the following:

(1) Programs of All-Inclusive Care for the Elderly (PACE) established pursuant to Chapter 8.75 (commencing with Section 14590).

(2) An organization that currently holds a designation as a federally qualified health center as defined in Section 1396d(l)(2) of Title 42 of the United States Code.

(3) An organization that currently holds a designation as a federally qualified rural health clinic as defined in Section 1396d(l)(1) of Title 42 of the United States Code.

(4) An applicant with the physical location of the center in an unserved area, which is defined as a county having no licensed and certified adult day health care center within its geographic boundary.

(5) Commencing May 1, 2006, an applicant for certification that meets all of the following:

(A) Is serving persons discharged into community housing from a nursing facility operated by the City and County of San Francisco.

(B) Has submitted, after December 31, 2005, but prior to February 1, 2006, an application for certification that has not been denied.

(C) Meets all criteria for certification imposed under this article and is licensed as an adult day health care center pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code.

(6) An applicant that is requesting expansion or relocation, or both, that has been Medi-Cal certified as an adult day health care center for at least four years, is expanding or relocating within the same county, and that meets one of the following population-based criteria as reported in the California Long Term Care County Data Book, 2002:

(A) The county is ranked number one or two for having the highest ratio of persons over 65 years of age receiving Medi-Cal benefits.

(B) The county is ranked number one or two for having the highest ratio of persons over 85 years of age residing in the county.

(C) The county is ranked number one or two for having the greatest ratio of persons over 65 years of age living in poverty.

(7) An applicant for certification that is currently licensed and located in a county with a population that exceeds 9,000,000 and meets the following criteria:

(A) The applicant has identified a special population of regional center consumers whose individual program plan calls for the specialized health and social services that are uniquely provided within the adult day health care center, in order to prevent deterioration of the special population's health status.

(B) The referring regional center submits a letter to the Director of Health Services supporting the applicant for certification as an adult day health care provider for this special population.

(C) The applicant is currently providing services to the special population as a vendor of the referring regional center.

(D) The participants in the center are clients of the referring regional center and are not residing in a health facility licensed pursuant to subdivision (c), (d), (g), (h), or (k) of Section 1250 of the Health and Safety Code.

(c) The moratorium shall not prohibit the department from approving a change of ownership, relocation, or increase in capacity for an adult day health care center if the following conditions are met:

(1) For an application to change ownership, the adult day health care center meets all of the following conditions:

(A) Has been licensed and certified prior to the effective date of this section.

(B) Has a license in good standing.

(C) Has a record of substantial compliance with certification laws and regulations.

(D) Has met all requirements for the change application.

(2) For an application to relocate an existing facility, the relocation center must meet all of the conditions of paragraph (1) and both of the following conditions:

(A) Must be located in the same county as the existing licensed center.

(B) Must be licensed for the same capacity as the existing licensed center, unless the relocation center is located in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(3) For an application to increase the capacity of an existing facility, the center must meet all of the conditions of paragraph (1) and must be located in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(d) Following the first 180 days of the moratorium period, the department may make exceptions to the moratorium for new adult day health care centers that are located in underserved areas if the center's application was on file with the department on or before the effective date of the act adding this section. In order to apply for this exemption, an applicant or licensee must meet all of the following criteria:

(1) The applicant has control of a facility, either by ownership or lease agreement, that will house the adult day health care center, has provided to the department all necessary documents and fees, and has completed and submitted all required fingerprinting forms to the department.

(2) The physical location of the applicant's or licensee's adult day health care center is in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(e) During the period of the moratorium, a licensee or applicant that meets the criteria for an exemption as defined in subdivision (d) may submit a written request for an exemption to the director.

(f) If the director determines that a new adult day health care licensee or applicant meets the exemption criteria, the director may certify the licensee or applicant, once licensed, for participation in the Medi-Cal program.

(g) The director may extend this moratorium, if necessary, to coincide with the implementation date of the adult day health care waiver.

(h) The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in any other section.

(Amended by Stats. 2007, Ch. 188, Sec. 46. Effective August 24, 2007.)

14043.47. (a) A provider doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group who utilizes nonphysician medical practitioners to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries shall meet the specific supervisory requirements applicable to such providers, pursuant to the Business and Professions Code or other state or federal law.

(b) A provider doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group who fails to comply with the requirements of this section is subject to temporary suspension from the Medi-Cal program and deactivation of the provider's number, including all business addresses.

(c) A physician doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group may not be enrolled at more than three business addresses unless there is a ratio of at least one physician providing supervision for every three locations.

(d) A physician doing business as a sole proprietorship, partnership, or professional medical corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group who fails to comply with the requirements of this section is subject to temporary suspension from the Medi-Cal program and deactivation of all of his or her number, including all business addresses.

(Amended by Stats. 2007, Ch. 188, Sec. 47. Effective August 24, 2007.)

14043.5. Subject to Article 4 (commencing with Section 19130) of Chapter 5 of Division 5 of Title 2 of the Government Code, the department may enter into contracts to secure consultant services or information technology including, but not limited to, software, data, or analytical techniques or methodologies for the purpose of fraud or abuse detection and prevention. Contracts under this section shall be exempt from the Public Contract Code.

(Added by Stats. 1999, Ch. 146, Sec. 37. Effective July 22, 1999.)

14043.51. (a) For purposes of this section, the following definitions apply:

(1) “Department” means the State Department of Health Care Services.

(2) “Electronic visit verification system” has the same meaning as that term is defined in subsection (l) of Section 1396b of Title 42 of the United States Code.

(3) “Partners” means governmental entities, including, but not limited to, the State Department of Social Services, the State Department of Developmental Services, the State Department of Public Health, the California Department of Aging, and the Office of Technology and Solutions Integration.

(4) “Provider” means a provider who is enrolled in the Medi-Cal program, as specified in subdivision (h) of Section 14043.1.

(b) The department, as the single state agency for the Medicaid program in California, may undertake action, as determined by the director to be appropriate, to implement an electronic visit verification system for purposes of obtaining and maintaining federal approval or ensuring federal financial participation is available or not otherwise jeopardized.

(c) The department may collaborate and contract with other governmental entities, including its partners, to comply with federal requirements relating to electronic visit verification.

(d) (1) If a provider renders Medi-Cal services that are subject to electronic visit verification, they shall comply with requirements, as established by the department and its partners, relating to electronic verification of those services.

(2) Except as provided in paragraph (3), if the department determines a provider has failed to comply with the established requirements, the department and its partners, as may be appropriate under the circumstances, may take any of the following action to address the noncompliance of the provider:

(A) Provide technical assistance on compliance.

(B) Require an approved corrective action plan.

(C) Recover associated overpayments.

(D) Impose enrollment or monetary sanctions.

(E) Take any other remedial action, as deemed appropriate.

(3) Individual providers of in-home supportive services, and individual providers of waiver personal care services, who are not employed by an agency, are not subject to the actions described in paragraph (2) for purposes of noncompliance with requirements established pursuant to paragraph (1), and are instead subject to the electronic visit verification system development and implementation principles set forth in Section 10836 and the provisions of Sections 12305.82 and 12305.83.

(e) (1) The department and its partners may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement this section and an electronic visit verification system.

(2) In developing and implementing electronic visit verification, the department and its partners may continue to utilize services performed under existing contracts if those services involve planning, developing, or establishing an electronic visit verification protocol or system.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and its partners may implement, interpret, or make specific this section, in whole or in part, by means of provider bulletins, plan letters, or other similar instructions, without taking any further regulatory action.

(Amended by Stats. 2023, Ch. 43, Sec. 68. (AB 120) Effective July 10, 2023.)

14043.55. (a) The department may implement a 180-day moratorium on the enrollment of providers in a specific provider of service category, on a statewide basis or within a geographic area, except that no moratorium shall be implemented on the enrollment of providers who are licensed as clinics under Section 1204 of the Health and Safety Code, health facilities under Chapter 2 (commencing with Section 1250) of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, or natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. This moratorium may be extended or repeated when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in Section 14105.3.

(b) If the Secretary of the United States Department of Health and Human Services establishes a temporary moratorium on enrollment as described in federal regulations, the department shall establish a corresponding moratorium covering the same period and provider types, even if those provider types would not ordinarily be subject to a moratorium under this section, unless the department determines that the imposition of the moratorium will adversely impact beneficiaries access to medical assistance. A federal moratorium adopted under this subdivision shall not be subject to the director's determinations regarding safeguards of public funds and program integrity or other prerequisites that are necessary to implement a state-initiated moratorium.

(Amended by Stats. 2015, Ch. 271, Sec. 8. (SB 299) Effective September 4, 2015.)

14043.6. (a) Except as provided in subdivision (b), the department shall automatically suspend, as a provider in the Medi-Cal program, any individual who, or any entity that, has a license, certificate, or other approval to provide health care, which is revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, 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. The automatic suspension shall be effective on the date that the license, certificate, or approval was revoked, lost, or surrendered.

(b) The department may elect to not suspend an individual or entity as a provider in the Medi-Cal program pursuant to subdivision (a) if the revocation, suspension, or loss of the individual or entity's license, certification, or approval authority in another state or the pending disciplinary hearing during which the individual or entity surrendered the license, certification, or approval authority in another state is based solely on conduct that is not deemed to be unprofessional conduct under California law. The department shall seek any federal approvals it deems necessary to implement this subdivision. This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific subdivision (b), in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or similar written instructions.

(Amended by Stats. 2023, Ch. 261, Sec. 4. (SB 487) Effective January 1, 2024.)

14043.61. (a) A provider shall be subject to suspension if claims for payment are submitted for the services, goods, supplies, or merchandise provided, directly or indirectly, to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List, published by the department, to identify suspended and otherwise ineligible providers, or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

(b) Notwithstanding Section 100171 of the Health and Safety Code, the imposition of the sanction provided for in subdivision (a) shall be appealable in accordance with Section 14043.65.

(Amended by Stats. 2007, Ch. 188, Sec. 48. Effective August 24, 2007.)

14043.62. (a) The department shall deactivate, immediately and without prior notice, the provider's number, including all business addresses used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or 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. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

(b) For purposes of this section:

(1) “Mailing address” means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive general program correspondence.

(2) “Pay to address” means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive warrants.

(3) “Service or business address” means the address that the provider has identified to the department in its application for enrollment as the address at which the provider will provide services to program beneficiaries.

(Amended by Stats. 2007, Ch. 188, Sec. 49. Effective August 24, 2007.)

14043.65. (a) Notwithstanding any other law, any applicant whose application for enrollment as a provider or whose certification is denied; or any provider who is denied continued enrollment or certification, or denied enrollment for a new location, who has been temporarily suspended, who has had payments suspended, who has had one or more business addresses used to obtain reimbursement from the Medi-Cal program deactivated, or whose provisional provider status or preferred provisional provider status has been terminated pursuant to this article or Section 14107.11, or Section 100185.5 of the Health and Safety Code, or who has had a civil penalty imposed pursuant to subdivision (a) of Section 14123.25; or any billing agent, as defined in Section 14040, when the billing agent’s registration has been denied pursuant to subdivision (e) of Section 14040.5, may appeal this action by submitting a written appeal, including any supporting evidence, to the director or the director’s designee. If the appeal is of a suspension of payment pursuant to Section 14107.11, the appeal to the director or the director’s designee shall be limited to the credibility of the allegation supporting the payment suspension, as described in subdivision (d) of Section 14107.11, and shall not encompass investigation or adjudication of the allegation. The appeal procedure shall not include a formal administrative hearing under the Administrative Procedure Act and shall not result in reactivation of any deactivated provider numbers during appeal. An applicant, provider, or billing agent that files an appeal pursuant to this section shall submit the written appeal along with all pertinent documents and all other relevant evidence to the director or to the director’s designee within 60 days of the date of notification of the department’s action. The director or the director’s designee shall review all of the relevant materials submitted and shall issue a decision within 90 days of the receipt of the appeal. The decision may provide that the action taken should be upheld, continued, or reversed, in whole or in part. The decision of the director or the director’s designee shall be final. Any further appeal shall be required to be filed in accordance with Section 1085 of the Code of Civil Procedure.

(b) No applicant whose application for enrollment as a provider has been denied pursuant to Section 14043.2, 14043.36, or 14043.4 may reapply for a period of three years from the date the application is denied. The three-year period shall commence upon the date of the denial notice.

(Amended by Stats. 2012, Ch. 797, Sec. 20. (SB 1529) Effective January 1, 2013.)

14043.7. (a) The department may make unannounced visits to an applicant or to a provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. If an unannounced site visit is conducted by the department for any enrolled provider, the provider shall permit access to any and all of their provider locations. If a provider fails to permit access for any site visit, the application shall be denied and the provider shall be subject to deactivation. At the time of the visit, the applicant or provider shall be required to demonstrate 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, as indicated by, but not limited to, the following:

(1) Being open and available to the general public.

(2) Having regularly established and posted business hours.

(3) Having adequate supplies in stock on the premises.

(4) Meeting all local laws and ordinances regarding business licensing and operations.

(5) Having the necessary equipment and facilities to carry out day-to-day business for his or her practice.

(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) (1) Failure to remediate significant discrepancies in information provided to the department by the provider or significant discrepancies that are discovered as a result of an announced or unannounced visit to a provider, for purposes of enrollment,

continued enrollment, or certification pursuant to subdivision (a) shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. The director shall notify in writing the provider of the temporary suspension and deactivation of provider numbers, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this subdivision shall be in accordance with Section 14043.65.

(2) A notice of temporary suspension issued pursuant to paragraph (1) shall include the following:

(A) A list of discrepancies required to be remediated.

(B) The timeframe in which a provider may demonstrate to the department that the discrepancies identified pursuant to subparagraph (A) have been remediated. The timeframe in which a provider may remediate discrepancies shall not be less than 60 days from the date the notice of temporary suspension is issued.

(3) If a provider who has received a notice of temporary suspension pursuant to paragraph (1) demonstrates to the department that the discrepancies identified pursuant to subparagraph (A) of paragraph (2) have been remediated and meets the standards of participation within the timeframe specified in subparagraph (B) of paragraph (2), the department shall lift the temporary suspension and shall notify the provider that the temporary suspension has been lifted and that he or she is eligible to receive Medi-Cal reimbursement for services provided after the date the temporary suspension was lifted.

(4) If a provider has received a site visit pursuant to this section that results in a notice of temporary suspension pursuant to paragraph (1), and the provider fails to remediate the discrepancies identified pursuant to subparagraph (A) of paragraph (2) within the timeframe specified in subparagraph (B) of paragraph (2), the department shall send the provider a notice stating that the provider will be removed from enrollment as a provider in the Medi-Cal program by operation of law based on failure to remediate the discrepancies identified in the notice of temporary suspension.

(Amended by Stats. 2014, Ch. 844, Sec. 1. (SB 1315) Effective January 1, 2015.)

14043.75. (a) The director may, in consultation with interested parties, by regulation, adopt, readopt, repeal, or amend additional measures to prevent or curtail fraud and abuse. Regulations adopted, readopted, repealed, or amended pursuant to this section shall be deemed emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). These emergency regulations shall be deemed necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted, amended, or repealed pursuant to this section shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(b) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific Sections 14043.15, 14043.25, 14043.26, 14043.27, 14043.28, 14043.29, 14043.341, and 14043.38 by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific those provisions described in this subdivision, including all of the following:

(1) Notifying provider representatives of the proposed action or change. The notice shall occur at least 10 business days prior to the meeting provided for in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the action or change.

(3) Allowing for written input regarding the action or change.

(4) Providing at least 30 days' advance notice of the effective date of the action or change.

(Amended by Stats. 2012, Ch. 797, Sec. 23. (SB 1529) Effective January 1, 2013.)

14044. (a) The department may limit, for 18 months or less, the American Medical Association's Current Procedural Terminology Fourth Edition (CPT-4) codes, the National Drug Codes (NDC), the Healthcare Common Procedure Coding System (HCPCS) codes, or codes established under Title II of the Health Insurance Portability & Accountability Act of 1996 (42 U.S.C. Sec. 1320d et seq.) for which any provider may bill, or for which reimbursement to any person or entity may be made by, the Medi-Cal program or other health care programs administered by the department if either of the following conditions exist:

(1) The department determines, by audit or other investigation, that excessive services or billings, or abuse, has occurred, which may include the department's discovery or determination that a claim was submitted for reimbursement under the Medi-Cal

program for a nerve conduction test, electromyography, or procedures, tests, examinations, or other medical services that the department has specified requires a certain residency or board certification, but the records did not contain, or the person or entity submitting the claim for reimbursement did not have, the certificate or diploma required by Section 14170.11.

(2) The Medical Board of California or other licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine or the rendering of health care, and the limitation precludes the licensee from performing services that could otherwise be reimbursed by the Medi-Cal program or other health care programs administered by the department.

(b) The department may impose a limitation pursuant to subdivision (a) for one or more codes or any combination of codes after giving the provider notice of the proposed limitation and, if applicable, the opportunity to appeal pursuant to subdivision (c).

(c) (1) A provider who receives notice of a proposed limitation based on paragraph (1) of subdivision (a) shall have 45 days from the date of notice to appeal the limitation by providing to the department reliable evidence that excessive services or billings, or abuse, did not occur.

(2) The department shall review the evidence and issue a decision within 45 days of receipt of the evidence.

(d) If a limitation is imposed pursuant to paragraph (1) of subdivision (a), it shall take effect on the 46th day after notice of the proposed limitation was given or, if the limitation is timely appealed, 15 days after the department gives the provider notice of its decision to impose the limitation. If a limitation is imposed pursuant to paragraph (2) of subdivision (a), it shall take effect 15 days after notice of the proposed limitation was given.

(e) If the department's limitation could interfere with the provider's or other prescriber's ability to provide health care services to a beneficiary, the burden to transfer a patient's care to another qualified person shall remain the responsibility of the licensee.

(f) For purposes of this section, the following definitions apply:

(1) "Abuse" has the same meaning as defined in Section 14043.1.

(2) "Administered by the department" means administered by the department or its agents or contractors.

(3) "Excessive services or billings" means an amount that is substantially in excess of what the department reasonably expects from the provider, based on data regarding the provider or other providers in the health care community who provide substantially similar services to a substantially similar patient population, that is available to the department from any source, including the department.

(4) "Licensee" means a person licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(5) "Other prescriber" means that person who is not the primary or attending physician for a patient who is a beneficiary of the Medi-Cal program or other health care program administered by the department, and that person causes the department, or its agents or contractors, to provide reimbursement for a drug, device, medical service, or supply to the beneficiary.

(6) "Provider" has the same meaning as defined in Section 14043.1.

(Amended by Stats. 2004, Ch. 228, Sec. 10.7. Effective August 16, 2004.)

14045. (a) A provider shall not submit a reimbursement request to the Medi-Cal program containing a beneficiary's social security number if the department has issued that beneficiary a Medi-Cal beneficiary identification card containing a beneficiary number with the issuance date included in that number.

(b) This section shall not apply to the submission of a request by a provider for beneficiary eligibility.

(c) In order to reduce medical fraud and the black market for stolen social security cards, the State Department of Health Care Services may establish an automated HIPAA-compliant system using HIPAA transactions whereby all providers can access a beneficiary's identification card number for submitting reimbursement requests.

(d) When the provider makes a good faith effort to obtain a recipient's beneficiary identification card number, this section shall not apply to the following types of services, or the following provider types, until the time that the department is able to establish a system described in subdivision (c):

(1) A hospital licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A long-term health care facility, as defined in Section 1418 of the Health and Safety Code.

(3) A primary care clinic that is licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(4) Emergency medical transportation services.

(5) A hospital-based physician.

(Amended by Stats. 2008, Ch. 179, Sec. 246. Effective January 1, 2009.)