Instructions for Preparation of a Request for CPSP Dual Provider Models

1. The CPSP providers must jointly submit a request to the MCH Branch through the local perinatal services coordinator for approval of CPSP dual billing, as stated under the September 22, 1992 policy letter "Revised Medi-Cal Policy/Dual Service Provision by CPSP Providers".

2. The request must be based on the existence of an "Access" problem as defined in Program Letter 99-01.

3. The request must include a Dual Provider Agreement as outlined in the September 22, 1992 policy letter "Revised Medi-Cal Policy/Dual Service Provision by CPSP Providers" and the CPSP Program Letter 99-01.

4. The request should be on the form attached, "CPSP Provider – Dual Provider Agreement" with each provider's initials where indicated, each provider's identifying information, and an authorized signature representing each provider.

5. If the "CPSP Provider – Dual Provider Agreement" form is not used, each of the items must be included in a written agreement, with each item initialized by the authorized agent of each CPSP provider.

6. The local perinatal services coordinator from the local health department must also sign the "CPSP Provider – Dual Provider Agreement", indicating his/her approval.

7. Once approved, the written CPSP Provider – Dual Provider Agreement", between the appropriate CPSP applicants/providers, must be on file at each provider site for every patient for whom dual billing is used.

8. Each CPSP applicant seeking approval for Dual Provider Model must submit a separate application form. Each applicant will be certified under his/her individual Medi-Cal provider number.

CPSP PROVIDER
DUAL PROVIDER AGREEMENT

		INITIALS Provider #1	INITIALS Provider #2
1.	The CPSP provider that bills the initial combined assessment (Z6500) or any of the initial assessment procedures (Z6300, Z6402, Z6200) will be the Case Coordinator for all services using the Individualized Care Plan. This provider will inform the patient that they are her case coordinator for all CPSP services. (Refer to California Code of Regulations (CCR) section 51179.7 – "Case Coordination")	_____	_____
2.	Each provider will maintain a description of how medical records will be shared and billing coordinated between providers during the antenatal, intrapartum and postpartum periods of care.	_____	_____
3.	Each provider will bill only for the services that the provider directly renders. There will be no duplicate billing of services, and service limits as specified in regulations **for an individual patient** will not be exceeded. (Refer to CCR section 51504, "Comprehensive Perinatal Services")	_____	_____
4.	If more than one provider provides OB services, each provider will bill on a fee-for-service basis for all services provided (e.g., neither provider will bill globally.)	_____	_____
5.	If only one CPSP provider provides the OB portion of care, global billing is allowable.	_____	_____
6.	Each patient will be provided written instructions telling her how and where to obtain emergency care during the course of her pregnancy.	_____	_____
7.	When billing for a CPSP service which has a prerequisite requirement that has been performed and billed by another provider, the biller must indicate in the "Remarks" portion of the Medi-Cal claim form that the prerequisite service was performed by another identified provider. (e.g., identified by name and Medi-Cal provider number.)	_____	_____
8.	Care will be provided under only one "Individualized Care Plan" for each patient.	_____	_____

Provider #1:

PROVIDER NAME

ADDRESS

CITY, STATE, ZIP CODE

MEDI-CAL PROVIDER NUMBER

AUTHORIZED AGENT, SIGNATURE

TITLE OF AUTHORIZED AGENT

DATE OF AGREEMENT

Provider #2:

PROVIDER NAME

ADDRESS

CITY, STATE, ZIP CODE

MEDI-CAL PROVIDER NUMBER

AUTHORIZED AGENT, SIGNATURE

TITLE OF AUTHORIZED AGENT

DATE OF AGREEMENT

I, the Local Perinatal Services Coordinator, approve this dual provider agreement:

Name: _____

Title: _____

Agency: _____

Date: _____

I, a representative of the Department of Health Services, Maternal and Child Health Branch, approve this Dual Provider Model:

Name: _____

Title: _____

Agency: _____

Date: _____