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*The CalOptima Provider Manual contains two or more versions of this section, covering information for Medi-Cal, OneCare (HMO SNP) and OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).

For access to CalOptima’s policies and procedures and common forms, please visit the Provider section of CalOptima’s website.
A1: WELCOME TO CALOPTIMA!

Thank you for your interest and participation in CalOptima. We are a county organized health system that administers health insurance programs for Orange County children, low-income families, seniors and persons with disabilities. Through the collaboration of physicians, care managers and other health care providers, CalOptima’s health insurance programs are built on a foundation of comprehensive and coordinated patient-centered care. Our aim is to help our members obtain quality health care delivered at the right place and at the right time.

We recognize that the strength of our programs depends upon strong collaboration and communication with our provider partners and their staff. We enjoy working with each provider and his or her staff to provide our members with high-quality, cost-effective care.

INTENT OF THIS MANUAL

This provider manual is a communication tool and a reference guide for CalOptima’s providers and their office staff. It contains basic information about how to work with CalOptima. We wrote the manual in a way that emphasizes:

- Essential information that providers need to know
- Steps that providers should take to complete any CalOptima-related transaction
- How to get more information

NOTICE: CalOptima reserves the right to modify, amend or implement new policies and procedures that are addressed in this manual. This manual is reviewed and updated periodically to address such changes. In the event of a conflict or inconsistency between this manual and other documents or laws, the following shall apply in the order of descending precedence: federal and state statutes, regulations and regulatory guidance; the provider contract with CalOptima; CalOptima policies and procedures; and finally, this provider manual.

HOW TO USE THE MANUAL

We drafted the manual so that it is easy to search and access through CalOptima’s website. Providers can simply search for particular topics by reviewing the manual’s table of contents or by using the Adobe word search function. We organized the manual’s contents to highlight subjects of greatest interest to most providers under the heading of “Important Topics,” including:

- Services Covered or Administered by CalOptima
- Services Covered by Other Agencies
- Eligibility Verification and Enrollment
- Authorization and Referral Guidelines
- Claims and Billing Guidelines
- Pharmacy and Prescriber Information

We also included information on other additional important functions and services in the manual. We encourage providers to become familiar with the contents of the provider manual and to refer to it frequently. Please contact the Provider Relations department with any suggestions for additions or improvements to this manual.
BACKGROUND ON CALOPTIMA

CalOptima is a county organized health system (COHS) that manages programs funded by the state and federal governments, but that operates independently. We are governed by a Board of Directors appointed by the Orange County Board of Supervisors, made up of members, providers, business leaders and local government representatives. CalOptima was created by the Orange County Board of Supervisors to ensure the delivery of quality health care services to local residents. Our members have access to a comprehensive network of providers that includes 1,700 primary care providers, 4,200 specialists, 490 pharmacies and a majority of hospitals and long-term care facilities in Orange County.

We currently provide health coverage through four major programs:

- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
- PACE (Program of All-Inclusive Care for the Elderly)

Our mission is simple:

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CALOPTIMA’S PROGRAMS

Medi-Cal

Medi-Cal is California’s Medicaid program for low income families, children, seniors and persons with disabilities. Under the provisions of Title 22 of the California Code of Regulations, the Department of Health Care Services (DHCS) administers the Medi-Cal program and has responsibility to formulate policy that conforms to federal and state requirements. The objective of the Medi-Cal program is to provide essential medical care and services to preserve health, alleviate sickness and mitigate handicapping conditions for eligible beneficiaries. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment.

Individuals and families apply for Medi-Cal through their county Department of Social Services and through Covered California. Applications may be completed in person, online, through the mail or over the phone. Elderly and disabled individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month-to-month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. In some case, eligibility for Medi-Cal can also be effective retroactively. Please note that a member’s eligibility must be verified before delivery of services and that the CalOptima identification card alone is not a guarantee of eligibility.

Not all Medi-Cal beneficiaries are CalOptima members. Those who are not CalOptima members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary. Any necessary prior authorization for elective services (referred to as an “Authorized Referral Request,” formerly known as “Treatment Authorization Request” or “TAR”) for Medi-Cal beneficiaries not covered by CalOptima should be submitted to the Medi-Cal field office, not to CalOptima.
Newly eligible Medi-Cal beneficiaries are covered through Fee-for-Service (FFS) Medi-Cal for their initial month of eligibility. New members will then be assigned to CalOptima on the first of the next month after their eligibility has been established. If members requested and received eligibility for any prior months, known as retroactive eligibility, these months would be covered through FFS. There are no mid-month enrollments for newly eligible members; only a reinstated member can be processed mid-month into Medi-Cal.

CalOptima will be responsible for any covered services as long as the member is enrolled with CalOptima, regardless of when annual eligibility redetermination is conducted. If a member loses eligibility due to not fulfilling their redetermination, the member may be reinstated to FFS or CalOptima. If the member completes the redetermination process within 60 days after their eligibility redetermination date, their eligibility will be made retroactive to that date, and the member will be covered by CalOptima for the entire process. CalOptima will be responsible for services provided to a CalOptima Medi-Cal member whose annual eligibility redetermination occurs within 60 days after the member’s annual eligibility redetermination date.

Providers should always verify eligibility prior to rendering services to ensure eligibility and to determine if coverage is through FFS Medi-Cal or CalOptima.

**OneCare (HMO SNP)**

OneCare is a Medicare Advantage Special Needs Plan for low income seniors and persons with disabilities who qualify for both Medicare and Medi-Cal. Patients who are dually eligible for Medicare (have Parts A and B) and Medi-Cal, and who currently reside in Orange County, can enroll in OneCare. Under their Medi-Cal eligibility, patients may have full Medi-Cal benefits or have some Medi-Cal assistance for their Medicare cost-sharing under the Qualified Medicare Beneficiaries (QMBs) program or the Specified Low-Income Medicare Beneficiaries (SLMBs) program.

OneCare offers a number of important advantages for members and their providers:

- OneCare offers enhanced care coordination and streamlined health care delivery by combining Medicare, Medicare prescription drug and Medi-Cal benefits into a single plan. OneCare’s goal is to make it easier for our members to understand and access health care services. Through enhanced care coordination and a single easy-to-understand benefit package, we also support our providers’ ability to furnish comprehensive patient-centered care for their patients.

- OneCare has an established provider network, which includes more than 3,350 primary care physicians and specialty care physicians.

- OneCare also provides additional benefits beyond traditional Medicare and Medi-Cal services, including no-cost prescriptions, dental, vision, and transportation services to and from medical appointments.

- Today, OneCare has an enrollment of more than 17,000 members, reflecting the strength of these advantages.

**OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)**

OneCare Connect is part of a national pilot program for people with Medicare and Medi-Cal (known as Medi-Medi or dual eligible). California implemented Cal MediConnect via legislation, called the Coordinated Care Initiative (CCI). CCI includes two main components:

- **Cal MediConnect**, which integrates Medicare and Medi-Cal into a single plan (instead of Medicare with Medi-Cal wrap)
  - CalOptima’s plan is **OneCare Connect**.

- Integration of two additional managed long-term services and supports as a managed care plan benefit
  - **Multipurpose Senior Services Program (MSSP)**
  - **In-Home Supportive Services (IHSS)**
The goals of the OneCare Connect program are to:

- Combine Medicare and Medi-Cal benefits
- Make meaningful improvements to member care with care coordination and planning
- Help members live safely at home as long as possible
- Protect member choice and provide a better health care experience

All OneCare Connect members must be:

- Eligible for full Medi-Cal benefits
- Enrolled in Medicare parts A, B, D
- Residents of Orange County
- Age 21 or older
- Medi-Cal members with a share of cost who reside in nursing homes, or who are enrolled in the Multipurpose Senior Services Program (MSSP) or have In-Home Supportive Services (IHSS) are also eligible

Members in Medicare Advantage plans, other Special Needs Plans or Program of All-Inclusive for the Elderly (PACE) are eligible for voluntary enrollment.

**Program of All-Inclusive Care for the Elderly (PACE)**

PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged just for the participant, based on their needs as determined by CalOptima’s Interdisciplinary Care Team.

PACE services include:

- Routine medical care, including specialist care
- Prescription drugs and lab tests
- Dental, vision, podiatry and hearing services (dentures, glasses, foot care and hearing aids)
- Social services
- Physical, occupational and speech therapies
- Personal care (bathing, dressing and light chores at home and in our day center)
- Recreation, social activities and nutritious meals
- Rides to health-related appointments, and to and from our day center
- Hospital care and emergency services*

To be a PACE participant, you must:

- Be at least 55 years old
- Live in our service area
- Be determined eligible for nursing facility services by the State of California
- Be able to live safely at home or in a community setting with proper support

*Participants must receive all needed services, other than emergency care, from CalOptima PACE providers and will be personally responsible for any unauthorized or out-of-network services.
CALOPTIMA’S DELIVERY SYSTEM

Providers have several options for participating in CalOptima’s programs. Providers can contract with a CalOptima health network, participate through CalOptima Direct or the CalOptima Community Network.

CalOptima members eligible to enroll in a health network have a right to select a primary care provider (PCP) and a health network. If a member does not make a voluntary selection within 45 days, CalOptima automatically assigns the member to a health network.

Each health network may have its own unique authorization, billing and service procedures, so providers should check with their health network representatives for more information. To serve a health network-enrolled member, providers can contract with the member’s health network.

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<td>Professional services and most ancillary services are the responsibility of the Shared-Risk Group. Facility services and some ancillary services are the responsibility of CalOptima.</td>
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*Note: Pharmacy services are not delegated to the health networks, except Kaiser Permanente.

Not all CalOptima members are health network-eligible. Members who are not eligible for enrollment in a health network may be assigned to CalOptima Direct based on the criteria outlined below:

<table>
<thead>
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<th>CalOptima Direct</th>
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Medi-Cal/Medicare Members (Medi-Medi)  
Members who reside outside of Orange County  
Medi-Cal share-of-cost members  
Members residing in Fairview Developmental Center |

For more information about how to participate in CalOptima’s program(s), providers can call CalOptima’s Provider Resource Line at 714-246-8600.
# B1: CalOptima Department and Program Contact Information

This section applies to the following CalOptima programs:

- Medi-Cal
- PACE
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

## CalOptima Contact Information

<table>
<thead>
<tr>
<th>Contact Information*</th>
<th>Phone Numbers and Website Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalOptima General Information</td>
<td>505 City Parkway West</td>
</tr>
<tr>
<td></td>
<td>Orange, CA 92868</td>
</tr>
<tr>
<td></td>
<td>General: 714-246-8500</td>
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<tr>
<td></td>
<td>Claims: 714-246-8885</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Website: <a href="http://www.caloptima.org">www.caloptima.org</a></td>
</tr>
<tr>
<td></td>
<td>TDD/TTY: 800-735-29299735</td>
</tr>
</tbody>
</table>

| CalOptima PACE                                | 13300 Garden Grove Blvd.                             |
|                                               | Garden Grove, CA 92843                               |
|                                               | 714-468-1100                                         |
|                                               | 855-785-2584 (toll-free)                            |

| CalOptima Website                            | www.caloptima.org                                    |

| Provider Resource Line                       | 714-246-8600                                        |

| Case Management Department                   | 714-246-8686                                        |

| Claims:                                       |                                                    |
|                                               | P.O. Box 11037                                      |
|                                               | Orange, CA 92856                                    |
|                                               | 714-246-8885                                        |

| CalOptima Direct Claims and Claims Provider Dispute Resolution | P.O. Box 11070                                      |
|                                                             | Orange, CA 92856                                    |
|                                                             | 714-246-8885                                        |

| Dual Eligible Claims (Crossover Claims)          | P.O. Box 11065                                      |
|                                                | Orange, CA 92856                                    |
|                                                | 714-246-8885                                        |

<p>| OneCare Connect Claims                         | P.O. Box 11065                                      |
|                                                | Orange, CA 92856                                    |
|                                                | 714-246-8885                                        |</p>
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<thead>
<tr>
<th>Contact Information*</th>
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<tr>
<td>Customer Service</td>
<td><strong>714-246-8500</strong> or <strong>888-587-8088</strong> (toll-free)</td>
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</tbody>
</table>
| Customer Service — OneCare Connect | **855-705-8823** (toll-free)  
  TDD/TTY Line: **800-735-2929** |
| Eligibility Verification | **800-463-0935** (toll-free) or **714-246-8540** |
| Compliance and Ethics Hotline | **877-837-4417** |
| Grievance and Appeals (Complaints) | 505 City Parkway West  
  Orange, CA 92868  
  **714-246-8554** |
| Health Education Referrals | **714-246-8500** or **888-587-8088** (toll-free)  
  Fax: **714-338-3127**  
  Email: healthpromotions@caloptima.org |
| Long-Term Care Authorizations | P.O. Box 11045  
  Orange, CA 92856  
  **714-246-8444** |
| Multipurpose Senior Services Program (MSSP) | **714-246-8500** or **888-587-8088** (toll-free) |
| Perinatal Support Services | **714-246-8686** |
| Prior Authorization/CalOptima Direct | **714-246-8686** or **888-587-7277** (toll-free) |
| Provider Data Management Services (PDMS) | P.O. Box 11033  
  Orange, CA 92856 |
| CalOptima Link | **www.caloptima.org** |
  OneCare Connect: 800-819-5480 (toll-free) |
| MedImpact Healthcare Systems, Inc. (Prior Authorizations) | Phone: 888-807-5705 (toll-free)  
  Fax: 858-357-2557 (toll-free) |
| California Children’s Services (CCS) | **714-347-0300** |
### Contact Information*

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<thead>
<tr>
<th>Health Network/Department</th>
<th>Phone Numbers and Website Addresses</th>
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<tr>
<td>Denti-CAL</td>
<td>800-322-6384 (toll-free)</td>
</tr>
<tr>
<td></td>
<td>TDD/TTY: 800-735-2922 (toll-free)</td>
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<tr>
<td>LIBERTY Dental Plan</td>
<td>888-704-9838 (toll-free)</td>
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<tr>
<td></td>
<td>TDD/TTY: 800-735-2929 (toll-free)</td>
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<tr>
<td>Medi-Cal Benefits/Department of Health Care Services (DHCS)</td>
<td>800-541-5555</td>
</tr>
<tr>
<td>Member Eligibility Verification (AEVS) — DHCS</td>
<td>800-456-2387 (toll-free)</td>
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<tr>
<td>CalOptima Behavioral Health</td>
<td>855-877-3885 (toll-free)</td>
</tr>
<tr>
<td>Regional Center of Orange County (RCOC) Referrals</td>
<td>714-796-5354</td>
</tr>
<tr>
<td>Vaccines for Children (VFC)</td>
<td>877-243-8832</td>
</tr>
<tr>
<td>Vision Service Plan (VSP)</td>
<td>Providers: 800-615-1883 (toll-free)</td>
</tr>
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<td>Members: 800-852-7600 (toll-free)</td>
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### HEALTH NETWORK CONTACT INFORMATION

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</tr>
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<tr>
<td>CalOptima Community Network</td>
<td>505 City Parkway West</td>
<td>General: 714-246-8500</td>
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<td>Orange, CA 92868</td>
<td>Claims: 714-246-8885</td>
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<td>Website: <a href="http://www.caloptima.org">www.caloptima.org</a></td>
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<td>TDD Line: 800-735-2929</td>
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<tr>
<td>AltaMed Medical Group (SRG)</td>
<td>2040 Camfield Avenue</td>
<td>General: 866-880-7805</td>
</tr>
<tr>
<td></td>
<td>Los Angeles, CA 90040</td>
<td>Claims: 866-880-7805</td>
</tr>
<tr>
<td></td>
<td></td>
<td>855-848-5252Website: <a href="http://www.altamed.org">www.altamed.org</a></td>
</tr>
<tr>
<td></td>
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<td>TDD Line: 714-246-8523</td>
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<tr>
<td>AMVI Care Health Network (PHC)</td>
<td>600 City Parkway West</td>
<td>General: 888-747-2684 (toll-free)</td>
</tr>
<tr>
<td></td>
<td>Suite 800</td>
<td>24 Hour: 888-747-2684 (toll-free)</td>
</tr>
<tr>
<td></td>
<td>Orange, CA 92868</td>
<td>Website: <a href="http://www.prospectmedical.com">www.prospectmedical.com</a></td>
</tr>
<tr>
<td>Arta Western Health Network (SRG)</td>
<td>1665 Scenic Ave. Suite 100</td>
<td>General: 800-780-8879 (toll-free)</td>
</tr>
<tr>
<td></td>
<td>Costa Mesa, CA 92627</td>
<td>24 Hour: 800-780-8879 (toll-free)</td>
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<tr>
<td></td>
<td></td>
<td>Website: <a href="http://www.healthcarepartners.com">www.healthcarepartners.com</a></td>
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<tr>
<td>Health Networks</td>
<td>Addresses</td>
<td>Phone Numbers and Website Addresses</td>
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<tr>
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</tr>
<tr>
<td><strong>CHOC Health Alliance (PHC)</strong></td>
<td>1120 W. La Veta Ave. Suite 450 Orange, CA 92868</td>
<td>General: 800-424-2462 (toll-free) 24 Hour: 800-424-2462 (toll-free) Website: <a href="http://www.chochealthalliance.com">www.chochealthalliance.com</a></td>
</tr>
<tr>
<td><strong>Family Choice Health Network (PHC/SRG)</strong></td>
<td>7631 Wyoming Street, Suite 202 Westminster, CA 92863</td>
<td>General: 800-611-0111 (toll-free) 24 Hour: 800-611-0111 (toll-free) Website: <a href="http://www.familychoicemedicalgroup.com">www.familychoicemedicalgroup.com</a></td>
</tr>
<tr>
<td><strong>HPN-Regal Medical Group (HMO)</strong></td>
<td>600 City Parkway West Suite 400 Orange, CA 92868</td>
<td>General: 800-747-2362 (toll-free) 24 Hour: 800-747-2362 (toll-free) Website: <a href="http://www.heritageprovidernetwork.com">www.heritageprovidernetwork.com</a></td>
</tr>
<tr>
<td><strong>Monarch Family HealthCare (HMO/SRG)</strong></td>
<td>11 Technology Drive Irvine, CA 92618</td>
<td>General: 888-656-7523 (toll-free) 24 Hour: 888-656-7523 (toll-free) Website: <a href="http://www.monarchhealthcare.com">www.monarchhealthcare.com</a></td>
</tr>
<tr>
<td><strong>Noble Mid-Orange County (SRG)</strong></td>
<td>10855 Business Center Drive Suite C Cypress, CA 90630-5252</td>
<td>General: 888-880-8811 (toll-free) 24 Hour: 888-880-8811 (toll-free) Website: <a href="http://www.noblemidoc.com">www.noblemidoc.com</a></td>
</tr>
<tr>
<td><strong>Prospect Medical Group (HMO)</strong></td>
<td>600 City Parkway West Suite 800 Orange, CA 92868</td>
<td>General: 800-708-3230 (toll-free) 24 Hour: 800-708-3230 (toll-free) Website: <a href="http://www.prospectmedical.com">www.prospectmedical.com</a></td>
</tr>
<tr>
<td><strong>Talbert Medical Group (SRG)</strong></td>
<td>1665 Scenic Ave., Suite 100 Costa Mesa, CA 92627</td>
<td>General: 800-297-6249 (toll-free) 24 Hour: 800-297-6249 (toll-free) Website: <a href="http://www.healthcarepartners.com">www.healthcarepartners.com</a></td>
</tr>
<tr>
<td><strong>United Care Medical Group (SRG)</strong></td>
<td>600 City Parkway West Suite 400 Orange, CA 92868</td>
<td>General: 877-225-6784 (toll-free) 24 Hour: 877-225-6784 (toll-free) Website: <a href="http://www.unitedcaremedicalgrp.com">www.unitedcaremedicalgrp.com</a></td>
</tr>
</tbody>
</table>

*Health Network Definitions:* “Health Network” means:

**Physician Hospital Consortium (PHC):** A PHC is a physician group contractually aligned with a primary hospital. PHCs are responsible for coordinating covered services to their assigned members. Please contact the member’s assigned PHC for additional information regarding covered services.
**Shared Risk Group (SRG):** SRG is a physician group partner who accepts delegated clinical and financial responsibility for professional services for assigned members and enters into a risk sharing agreement with CalOptima for the hospital services. Please contact the member’s assigned SRG for additional information regarding covered services.

**Health Maintenance Organization (HMO):** An HMO is a Knox-Keene licensed entity contracted by CalOptima to provide covered services to their assigned members. Please contact the member’s assigned HMO for additional information regarding covered services.
B2: PROVIDER RESOURCES ON CALOPTIMA’S WEBSITE

The CalOptima website (www.caloptima.org) provides information, resources and other helpful tools to providers. Resources include, but are not limited to:

- Provider Portal (aka CalOptima Link) — Contracted providers may use CalOptima Link to verify eligibility, view member rosters, check the status of a CalOptima claim, submit referrals for CalOptima Direct or CalOptima Community Network members, and access member profiles. Providers must register with CalOptima Link to utilize this service. Providers may register for CalOptima Link by using the following link: https://www.caloptima.org/en/Providers/ClaimsAndEligibility/CalOptimaLink.aspx
- Provider Manual — Provides general information relative to the provision of health care goods and services to CalOptima members.
- Provider Directory — Provider search by CalOptima program, health network, name, specialty or location.
- Pharmacy Resources — Obtain CalOptima’s Approved Drug List and locate CalOptima contracted pharmacies.
- Common Forms — From appeals and grievance forms to Wheelchair Repair Authorization Referral forms — they’re all here.
- Health and Wellness Library — Materials are available in PDF format to download in all of CalOptima’s threshold languages.
- Provider Communications — This includes the monthly provider newsletter, as well as Provider Updates based on recent Operating Instruction Letters received by the Department of Health Care Services.
- CalOptima Policies and Procedures via Compliance 360 — A complete library of CalOptima policies by program.
C1: COVERED SERVICES OVERVIEW

“Covered Services” refers to those medically necessary items and services available to a member through CalOptima’s Medi-Cal program. These services include Medi-Cal covered services and optional Medi-Cal services administered by CalOptima, as well as Medi-Cal covered services not administered by CalOptima.

MEDI-CAL COVERED SERVICES ADMINISTERED BY CALOPTIMA

Medi-Cal Covered Services administered by CalOptima include, but are not limited to:

- Physician services
- Hospital inpatient and outpatient services
- Emergency care services
- Health education programs
- Home health care
- Maternity care services
- Family planning
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CalOptima’s CHDP Program)
- Immunizations
- Prescription drugs
- Transportation — emergency
- Transportation — non-emergency medical transportation services
- Hospice
- Long-term care and skilled nursing care services
- Physical therapy/occupational therapy
- Vision services
- Mental health and substance use disorder services

MEDI-CAL COVERED SERVICES NOT ADMINISTERED BY CALOPTIMA

CalOptima does not administer certain Medi-Cal covered services. The following identifies these covered services, as well as where to obtain more information in this Provider Manual about referrals for these services:

- AIDS waiver services (see Section D1: AIDS Waiver Services Referrals)
- California Children’s Services (CCS) (see Section D3: California Children’s Services)
- Dental services (see Section D4: Dental Services for Medi-Cal Members)
- Drug and alcohol abuse services (see Section D2: Drug and Alcohol Abuse Services)
- Home- and community-based services (see Section D6: Home- and Community-Based Services Referrals)
- Genetically handicapped persons program (GHPP) (Located at www.dhcs.ca.gov)
Local education agency services (see Section K2: Local Education Agency Services)

For more information about Medi-Cal covered services, please follow the link below to the Medi-Cal website: www.medi-cal.ca.gov.

ONECARE SERVICES OVERVIEW

OneCare (HMO SNP)’s covered benefits includes services that are covered under Medicare and also includes extra services normally not covered under Medicare. OneCare’s Summary of Benefits provides a description of all benefits covered under OneCare, including Medicare benefits and any supplemental benefits. The Summary of Benefits also describes Medi-Cal covered benefits, which are in addition to Medi-Cal and Medicare supplemental benefits.

OneCare Covered Services include, but are not limited to:

- Physician services
- Inpatient hospital care
- Inpatient mental health care
- Skilled nursing facility
- Home health care
- Hospice
- Chiropractic services
- Podiatry services
- Outpatient mental health care
- Outpatient substance abuse care
- Medically necessary ambulance services
- Non-emergency medical transportation
- Emergency services
- Urgent care
- Outpatient rehabilitation services
- Durable medical equipment
- Prosthetic devices
- Diagnostic tests, X-rays, lab and radiology services
- Prescription drugs
- Hearing services
- Vision services
- Health club membership/fitness classes
- Acupuncture and other alternative therapies

To obtain a copy of OneCare’s Summary of Benefits, please visit the OneCare (HMO SNP) section of CalOptima’s website.

ONECARE CONNECT ADDED BENEFITS

In addition to Medicare and Medi-Cal covered services, OneCare Connect members will receive:

- Vision care and taxi rides to medical appointments
- Enhanced dental care
- Improved access to long-term services and supports, including skilled nursing, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), and Multipurpose Senior Services Program (MSSP) benefits
- Improved integration of behavioral health benefits with medical care benefits
- Coordination of benefits via an Interdisciplinary Care Team (ICT) and an Individualized Care Plan (ICP)
- Support from a Personal Care Coordinator (PCC) to help navigate the health care system

To obtain a copy of OneCare Connect’s Summary of Benefits, please visit the OneCare Connect section of the CalOptima website.
C2: Early and Periodic Screening, Diagnosis, and Treatment Referrals

This section applies to the following CalOptima programs:

Medi-Cal

C2: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT REFERRALS

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are initial, periodic or additional health assessments of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program.

Effective September 15, 2014, EPSDT services now include behavioral health treatment (BHT) for Medi-Cal eligible individuals less than 21 years of age diagnosed with autism spectrum disorder (ASD). BHT includes, but is not limited to, applied behavior analysis (ABA). Effective July 1, 2018, the EPSDT benefit of BHT services for Medi-Cal individuals will include members who meet medical necessity criteria and will no longer be limited to members diagnosed with ASD. Members who are eligible and who receive BHT services prior to July 1, 2018, with the Regional Center will transition their services to CalOptima. Medi-Cal individuals who enroll in CalOptima after July 1, 2018 will receive medically necessary BHT services through CalOptima.

SERVICES PROVIDED UNDER EPSDT

EPSDT supplemental services include, but are not limited to:

- Acupuncture
- Audiology
- BHT
- Chiropractic
- Cochlear implants
- Case management services
- Hearing aid batteries
- In-home private duty nursing
- Medical nutrition services
- Occupational therapy
- Pediatric day health care
- Speech therapy

To remember the elements of EPSDT, use the name of the program:

Early Identifying problems early, starting at birth
Periodic Checking children’s health at periodic, age-appropriate intervals
Screening Doing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
Diagnosis Performing diagnostic tests to follow up when a risk is identified
Treatment Treating any problem found
WHEN EPSDT SERVICES ARE COVERED

EPSDT services are subject to prior authorization. When medical necessity criteria have been met, such requests will be approved. Cases in which medical necessity criteria have not been met will be denied or modified as appropriate to meet the needs of the member.

- EPSDT services are provided to full-scope Medi-Cal beneficiaries who are under the age of 21. Services may be authorized once medical necessity criteria have been met.
- Authorized services must meet either the regular Medi-Cal definition of medical necessity or the EPSDT definition for medical necessity, which is outlined in CCR, Title 22, Division 3, Section 51003 or 51340(e).
- Authorized services must be cost-effective to the Medi-Cal program. This means, for example, that the individual cost of providing EPSDT private duty nursing services in home settings must be less than the total cost incurred by the Medi-Cal program for providing the care in a licensed health care facility.
- When necessary, a home health assessment will be arranged to validate the necessity of the requested services and to ensure that the home is an appropriate environment for the provision of the requested services.

HOW TO REFER A MEMBER FOR EPSDT

1. If a member is enrolled in a health network and requires referral to EPSDT services, the referring entity shall follow the health network’s authorization process for EPSDT services, including any of the following as appropriate for the service(s) requested:
   a. Nutritional assessment
   b. Home health evaluation
   c. Evidence of family/caretaker participation in care planning
   d. Treatment plan, goals, and anticipated time needed to meet therapeutic goals
   e. Specific outcome measurements

2. If a member is enrolled in CalOptima Direct (COD) or CalOptima Community Network (CCN), the referring entity shall complete the appropriate Authorization Referral Form (ARF), clearly marked “For EPSDT Services” on top of them.

3. In addition, for a member in the COD or CCN network, the provider must accompany authorization requests with medical documentation sufficient to support the medical necessity of the services. Required documentation must include any of the following as appropriate for the service(s) requested:
   a. Nutritional assessment
   b. Home health evaluation
   c. Evidence of family/caretaker participation in care planning
   d. Treatment plan, goals, and anticipated time needed to meet therapeutic goals
   e. Specific outcome measurements

4. If a member requires BHT services, the provider must submit the Behavioral Health - Authorization Request Form (BH-ARF) to the CalOptima prior authorization department. The request must contain the following supporting documentation:
   a. Supporting documentation of recommendation for BHT services
   b. Member-specific treatment plan
   c. Documentation of ongoing coordination of care and communication with member’s medical provider
   d. Documentation of ongoing coordination of care and communication with the member’s Local Education Agency (LEA) as applicable
e. Information that identifies the delivery of ABA services by a Qualified Autism Service Provider

5. On review of the materials and request, medical necessity criteria as detailed above will be applied. If needed, additional documentation may be requested to aid in decision making.

6. If you have questions regarding EPSDT, call CalOptima or the health network’s prior authorization department.

7. In addition, if a provider has a member who requires BHT for ASD, the provider should refer the member to call CalOptima Behavioral Health at 855-877-3885. This line is available 24 hours a day, seven days a week. TDD/TTY users can call 800-735-2929.

<table>
<thead>
<tr>
<th>CalOptima Policies and Procedures:</th>
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<tr>
<td>GG.1121: EPSDT Supplemental Services</td>
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<tr>
<td>GG.1548 Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder</td>
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C3: Hospice Service Referrals

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP), OneCare Connect (OCC)

C3: HOSPICE SERVICE REFERRALS

Hospice services are a covered benefit for CalOptima Medi-Cal, OneCare (HMO SNP), and OneCare Connect (Cal MediConnect) members. CalOptima and its health networks are responsible for providing hospice services, when medically indicated, for terminally ill members.

Hospice services can be provided in a skilled nursing facility, acute hospital setting, and in a community setting (home, assisted living, and board and care facility, etc.). However, hospice services are separate and distinct from the long-term care room and board benefit also covered by CalOptima.

Face-to-Face Encounter: A hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine initial and continued eligibility of the member. Failure to meet the face-to-face encounter requirements will result in a failure by the hospice provider to certify the terminal diagnosis and to meet eligibility requirements. The member would cease to be eligible for the benefit.

- Time frame of face-to-face encounters:
  - The initial face-to-face encounter occurs when the member chooses the hospice provider and establishes care.
  - The next encounters must occur no more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter.

Who Can Receive Hospice Care? CalOptima and its health networks, including CalOptima Community Network (CCN), are responsible for providing hospice services if all of the following criteria apply:

- A physician requests hospice services for the member and provides a physician’s order.
- The member has a terminal diagnosis.
- A hospice provider evaluates the member and determines that the member meets criteria for hospice services.
- The Notice of Election is signed by the member or authorized representative.

Who Coordinates and Pays for Hospice? Whether a CalOptima member is enrolled with a health network (including CCN) or in CalOptima Direct, it is critical to determine the entity responsible for the hospice services.

- **Health Network Members** — If a member is enrolled in a health network, that health network is responsible for ensuring hospice services are provided and this includes paying for Medi-Cal hospice services and hospice room and board services per Medi-Cal guidelines (see Division of Financial Responsibility-DOFR). Hospice respite care, continuous care and routine home care do not require prior authorization. General inpatient care does require prior authorization.

- **CalOptima Direct Medi-Cal Only Members including CalOptima Community Network (CCN)** — If a member is in CalOptima Direct or the CCN, CalOptima is responsible for ensuring services are provided and paid for Medi-Cal hospice services and hospice room and board per Medi-Cal guidelines (see Division of Financial Responsibility-DOFR). Hospice respite care, continuous care and routine home care do not require prior authorization. General inpatient care does require prior authorization. Fax Authorization Request Form for General Inpatient Hospice Care to CalOptima’s Long-Term Services and Supports department at 714-246-8843.
CalOptima Direct Medicare/Medi-Cal Members — For CalOptima Direct Medicare-Medi-Cal members, Medicare covers hospice services, while CalOptima Direct only pays for hospice room and board services per Medi-Cal guidelines.

HOW TO MAKE A REFERRAL FOR HOSPICE SERVICES

1. If a member needs hospice services, a provider (primary care provider) should work with the member and the member’s authorized representative to identify an appropriate hospice agency. Upon identifying an appropriate hospice agency, the provider should make the referral to the identified hospice agency.

2. If a member is in CalOptima Direct, the hospice agency will submit a Notification/Validation form to CalOptima’s Long-Term Services and Supports department at 714-246-8843. The Notification/Validation of Hospice services will be confirmed for hospice room and board.

3. If the member is dually eligible for Medicare and Medi-Cal, the hospice agency will submit the Notification/Validation form for room and board only to CalOptima’s Long-Term Services and Supports department at 714-246-8843. The hospice provider will work with Medicare for the Medicare services.

4. For questions about hospice services, providers can call the CalOptima Long-Term Services and Supports department at 714 246-8444.

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CalOptima Policies and Procedures:
GG.1503: CalOptima Hospice Coverage Notification and Validation Requirements
C4: Long-Term Care Service Referrals

This section applies to the following CalOptima programs:

- Medi-Cal
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

C4: LONG-TERM CARE SERVICE REFERRALS

CalOptima is responsible for Medi-Cal covered long-term care services. CalOptima pays the facility daily rate for members who need out-of-home placement in a long-term care facility due to their medical condition.

Types of Long-Term Care Facilities — Medi-Cal covered long-term care services include placement in the following types of facilities:

- Nursing Facility Level A (NF-A)
- Nursing Facility Level B (NF-B)
- Subacute Care Facilities — both adult and pediatric facilities
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Developmentally Disabled Habilitative (DD-H) or Developmentally Disabled Nursing (DD-N) for Medi-Cal only members

It is important to note that the Medi-Cal long-term care benefit does not include or pay for assisted living or board and care facility services.

Criteria for Admission — The Medi-Cal long-term care benefit has specific criteria for admission to each type of long-term care facility based upon the member’s diagnosis, physical limitations and medical treatment needs. If a provider intends to refer a CalOptima member to a nursing facility, it is important to understand Medi-Cal’s facility-specific criteria. Providers can use the following link to find the long-term care admissions criteria for each type of facility: [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov/)

TIPS FOR REFERRING A MEMBER TO A NURSING FACILITY

Here are several important tips for physicians intending to refer a CalOptima member to a nursing facility:

1. To refer a member to a nursing home, the physician must order the admission and supply the following information:
   a. The member’s medications, diet, activities and medical treatments, such as wound care and labs
   b. A current history and physical
   c. Diagnosis/diagnoses
   d. Indication of whether the physician will be following the member once admitted to the facility

2. In making the referral, the physician must identify the facility of admission. The member and/or member’s authorized representative may also seek the physician’s counsel in determining an appropriate facility. Please use the link below to navigate to the Long-Term Care page of CalOptima’s website, which contains the list of CalOptima contracted facilities: [www.caloptima.org](http://www.caloptima.org)

3. The admitting facility is responsible for obtaining authorization from CalOptima. The admitting facility will present medical justification for the level of care requested.

4. If the authorization request is not approved or is modified, the member, physician or facility has an option to appeal by submitting additional documentation. There are specific timelines to submit an appeal based on whether the denial was administrative or level of care.
a. An administrative denial appeal is submitted to CalOptima’s Grievance and Appeals department within 365 days of the decision. There is only one level of appeal.

b. A level of care denial/modification appeal must be presented within 60 days of the decision. If the denial is upheld, it can be appealed a second time through the Grievance and Appeals department if presented within 365 days of original decision.

c. For more information on how to file an appeal, please see Section R1: Provider Complaint Process.

PLAN OF CARE FOR ONECARE CONNECT MEMBERS

1. OneCare Connect members admitted to a long-term care facility, including a skilled nursing facility for Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B) or Subacute Facility — Adult/Pediatric shall have an individually written plan of care completed, approved and signed by a physician.

2. A nursing facility may modify its care or discharge a OneCare Connect member if the nursing facility determines that the following specified circumstances are present:

   a. The nursing facility is no longer capable of meeting the member’s health care needs.
   b. The member’s health care has improved sufficiently so that the member no longer needs nursing facility services.
   c. The member poses a risk to the health or safety of individuals in the nursing facility.

3. CalOptima and/or its health network shall participate in member’s interdisciplinary care team meeting as appropriate. When one of the circumstances above presents itself, CalOptima or its health networks shall arrange, coordinate and collaborate with the nursing facility to discharge a OneCare Connect member to the appropriate setting.

4. A nursing facility shall maintain a member’s plan of care in the member’s medical record at the nursing facility.

5. A nursing facility interdisciplinary care team including physicians, nurses, therapists, social workers and other health care professionals shall establish a written plan of care for a member according to state and federal regulations. The plan of care shall include:

   a. Diagnoses, symptoms, complaints and complications indicating a need for facility admission
   b. A description of the functional level of the member
   c. Objectives for the member during the facility stay
   d. Any orders for medication, treatment, restorative and rehabilitative services, activities, therapies, social services, diet, special procedures recommended for health and safety of the member, and special procedures designed to meet the objective of the plan of care
   e. Plans for continuing care, including review and modification of the plan of care
   f. Plans for discharge
   g. Plans for leave of absence and summer camp, if applicable

6. The attending primary care provider and other members involved in the member’s care shall review and sign each plan of care at least every 90 calendar days for nursing facilities.

7. The CalOptima LTSS staff is responsible for completing an initial and annual health risk assessment and care plan for CalOptima members residing in a nursing facility.
8. Per LTC nursing facility regulations, the nursing facility staff shall review and update the plan of care on a regular basis and as the member’s health condition changes, such as when a member:
   a. Has an emergency room visit
   b. Is admitted to an acute hospital
      Has a sudden increase in polypharmacy

For questions about the Medi-Cal long-term care benefit or about referrals to long-term care facilities, please call the CalOptima Long-Term Care department at **714-246-8444**.

**CalOptima Policies and Procedures:**

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C5: MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

The Multipurpose Senior Services Program (MSSP) helps frail, elderly Medi-Cal members remain in their homes and avoid admission into hospitals or nursing homes. MSSP provides a variety of services, including care management, emergency response systems, community referrals, purchased personal care services/housekeeping services (in the absence of In-Home Supportive Services), transportation, home-delivered meals, social services and other services. MSSP is a statewide program funded by the California Department of Aging (CDA) that CalOptima administers as the host agency in Orange County.

Who is Eligible for MSSP? There are several qualifying criteria that members must meet to participate in MSSP. Members must:

- Be certifiable for placement in a nursing facility (member could otherwise be in a nursing facility)
- Be age 65 or older
- Receive Medi-Cal under an appropriate aid code (1D, 2D, 6D, 1E, 2E, 6E, 1X, 1Y, 10, 14, 16, 18, 1H, 20, 24, 26, 28, 60, 64, 66, 68, 6H)
- Not have a Medi-Cal share of cost
- Reside in Orange County
- Be able to be served within MSSP’s cost limitations
- Be appropriate for care management services

Determining Who Will Benefit from MSSP — The goal of the MSSP program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of frail members. Members who will benefit from MSSP will have a need for care management as well as an ability and willingness to participate in care management.

- “Need for care management” means that the member requires assistance in accessing community services, maintaining or effectively using available services, and/or managing serious health conditions.
- “Ability/willingness to participate” means that the member/member’s representative or caregiver is able to cooperate in formulating and then carrying out the care plan.

By appropriately placing frail, elderly members in MSSP, CalOptima provides care at a cost below what would otherwise be expended on nursing facility care and maintain the member in his or her home environment.

CASE MANAGEMENT AND COORDINATION OF CARE

- CalOptima and its affiliated health networks will work the CalOptima MSSP provider to provide case management and coordination of care for CalOptima members.
- CalOptima’s MSSP provider will participate in the care management team that includes an Interdisciplinary Care Team (ICT) of health professionals.
- CalOptima informs its members about the CalOptima MSSP program and establishes a process to refer members who enrolled in Medi-Cal for Managed Long-Term Services and Supports (MLTSS) and are potentially eligible for the MSSP program to the MSSP provider for eligibility determination.
- CalOptima and the CalOptima MSSP provider will coordinate and work collaboratively on care coordination care activities for the MSSP member.
CalOptima shall notify the CalOptima MSSP provider within five business days of a CalOptima member’s disenrollment from CalOptima.

CalOptima’s MSSP providers will accept referrals from any sources including a CalOptima case manager, health networks, members, member’s representative or caregiver, acute hospital care managers, nursing facilities, and/or other community-based organizations.

Since MSSP’s inception in 2001, CalOptima has contracted with the California Department of Aging to host the MSSP site. MSSP is budgeted and reimbursed through monthly reconciliation of CalOptima members who are enrolled in the Program.

CalOptima will verify the Medi-Cal eligibility and plan enrollment status of each MSSP member on a monthly basis.

CalOptima and its health networks will identify, refer and provide care coordination for MSSP-eligible members.

CalOptima will utilize the MSSP member’s assessment data to develop an Individualized Care Plan (ICP) based on the member’s risk, co-morbidity, complexity of medical condition(s) and functional status.

CalOptima will provide initial and ongoing training for the MSSP program being integrated into CalOptima as a managed care benefit.

CalOptima and the CalOptima MSSP provider will maintain confidentiality of all member records and information.

**APPEALS, GRIEVANCES AND COMPLAINTS PROCESS**

- An MSSP member whose services have been denied, reduced, suspended or terminated from MSSP has the right to initiate a request for a State Hearing within 90 calendar days. At any time during this process, a member may submit a Withdrawal of Request for State Hearing Form.

- In the event a CalOptima member does not meet California Department of Aging (CDA) MSSP eligibility criteria and appropriateness for participation in MSSP after a home evaluation and initial face-to-face assessment is completed, the member has the right to initiate a request for a State Hearing within 90 calendar days. At any time during this process, a member may submit a Withdrawal of Request for State Hearing Form. A written notice and/or State Hearing are not required if someone chooses not to participate, or does not meet the criteria for age, Medi-Cal eligibility or residence.

To request a State Hearing, members may write to:

1. CA Department of Social Services
   State Hearing Division
   PO Box 944243, Mail Station 19-37
   Sacramento, CA 94244-2430

2. Or fax to 916-229-4110

3. The member may also request a hearing by calling the Public Inquiry and Response Unit at 800-952-5253 or use TDD: 800-952-8349.

- CalOptima MSSP provider shall issue a Notice of Action (NOA) for any adverse decisions regarding MSSP enrollment, or when a Waiver Service is denied, reduced, suspended or terminated by the MSSP provider. The NOA is mailed to a member informing of rights to file an appeal, grievance or complaint with the California Department of Social Services, State Hearing Division.

- If a member disagrees with the CalOptima MSSP provider’s decision, he or she must complete and submit the Request for a State Hearing Form within 90 calendar days to the Office of the Chief Referee at the California Department of Social Services (CDSS).
- CalOptima MSSP provider shall retain the responsibility to receive, acknowledge, respond and track MSSP appeals, grievances and complaints, and manage the State Hearing process for MSSP waiver participants and CalOptima members receiving MSSP services.
- CalOptima Grievance and Appeals department shall manage appeals, grievances and complaints for non-related MSSP services for MSSP waiver participants, in accordance with CalOptima Policies CMC.9001: Member Complaint Process and HH.1102: CalOptima Member Complaint.
- CalOptima LTSS department shall be responsible for reporting MSSP appeals, grievances and complaints statistics and analysis to LTSS Quality Improvement (QI) Subcommittee quarterly.
- When a member files a timely appeal of CalOptima MSSP provider’s decision to terminate the member from MSSP services, the MSSP member shall be entitled to continue receiving Aid Paid Pending for waiver services (including care management) until the State Hearing Administrative Law Judge (ALJ) has rendered a final decision.
- Upon receipt of a member's Appeal, CDSS shall complete the following:
  1. Review the Request for a State Hearing Form.
  2. Make a determination whether the appeal is granted or denied.
  3. If denied, CDSS shall notify the member of the denial.
  4. If granted, CDSS shall assign the appeal to an Administrative Law Judge (ALJ) who will precede the State Hearing.
  5. Notify CalOptima Grievance and Appeals (GARS) department that an appeal was filed.
- CalOptima GARS shall provide the CalOptima MSSP provider with the date, place and time of the hearing.
- The CalOptima MSSP provider participates in a State Hearing by:
  1. Developing a written position statement in response to the appeal request
  2. Attending the hearing by telephone and
  3. Responding to questions and presenting additional information to the ALJ.

Upon the ALJ’s rendering the final decision:

  1. CDSS shall notify the member and CalOptima GARS department
  2. CalOptima GARS shall notify the CalOptima MSSP provider of the ALJ's decision within three business days; and
  3. The CalOptima MSSP provider shall send a Letter of Notification to CalOptima member within three business days after notification from CalOptima GARS.

- CalOptima’s GARS department shall coordinate all State Hearing actions with the CalOptima MSSP provider in accordance with Policy HH.1108: State Hearing Process & Procedures.
- MSSP provider shall be responsible for reviewing position statement and all health records related to MSSP services; and
- CalOptima GARS department shall review the position statement and all health records for all other non-MSSP related services.

On a quarterly basis, the CalOptima MSSP provider shall submit a report of member's appeals, grievances and complaints, to CalOptima LTSS and GARS departments during the 19-month transition period in which the MSSP benefit is being integrated into CalOptima, as described in All Plan Letter (APL) 15-002: Multipurpose Senior Services Program, Complaint, Grievance, and State Hearing Responsibilities in CCI Counties.
The MSSP provider shall communicate any non-MSSP related appeals, grievances and complaints to GARS.

The CalOptima GARS department shall communicate any MSSP related appeals, grievances and complaints that are received internally to MSSP provider.

Upon receipt of member's appeal, grievance or complaint, CalOptima GARS department shall keep records using an internal tracking system such as: decisions, dates and resolutions.

HOW TO REFER A MEMBER TO MSSP

To refer a member to CalOptima’s MSSP program, please complete a Senior Select Intake Form and fax the form to CalOptima at 714-246-8680. To obtain a copy of the Intake Form, please access the Providers section of CalOptima’s website.

ROLE OF THE PHYSICIAN AND MSSP

The MSSP care managers often need to work together with the member’s primary care provider (PCP) to coordinate and arrange for certain services. Please be aware that CalOptima’s MSSP staff may contact a member’s PCP to obtain a prescription or order for a specific item or service (e.g., durable medical equipment).

For questions about the MSSP program or about how MSSP is addressing the needs of a specific member, contact CalOptima’s MSSP program at 714-347-5780.

CalOptima Policies and Procedures:
- GG.1831: Multipurpose Senior Services Program (MSSP)
- GG.1832: Multipurpose Senior Services Program (MSSP) – MSSP Identification, Referral, and Coordination of Care Process
- GG.1834 Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process
C6: LONG-TERM SERVICES AND SUPPORTS (LTSS)

OVERVIEW

CalOptima administers the following Long-Term Services and Supports (LTSS):

- Long-Term Care (LTC) as a Medi-Cal managed care plan benefit (Section C4: Long-Term Care Service Referrals)
- Community-Based Adult Services (CBAS) as a Medi-Cal managed care benefit
- Multipurpose Senior Services Program (MSSP) as a Medi-Cal managed care plan benefit (Section C5: Multipurpose Senior Services Program).

Who should be referred for LTSS? Members who:

- Need social support
- Need assistance with activities of daily living
- Qualify for a nursing home but want to stay at home
- Need caregiver support
- Have issues with current LTSS services
- Indicate they need more support
- Have a history of repeated hospitalization
- Request non-medical help

COMMUNITY-BASED ADULT SERVICES (CBAS)

CalOptima is responsible for determining CBAS eligibility and medical necessity criteria. Kaiser Health Foundation will determine CBAS eligibility for Kaiser Permanente members only (CalOptima will manage all aspects of CBAS for Kaiser Foundation members). CalOptima and Kaiser may receive an inquiry for CBAS from a variety of sources, including: CBAS center, a member or member's authorized representative, a member's primary care provider (PCP) or specialist, a member's case manager or personal care coordinator. CalOptima or Kaiser may also initiate an evaluation based on the results of the member's initial risk stratification or health risk assessment results. For members assigned to CalOptima and health networks, excluding members assigned to Kaiser, CalOptima's LTSS staff shall process all CBAS benefit inquiries and CBAS authorization requests; Kaiser will process all CBAS inquiries and authorization requests for Kaiser Permanente members.

CBAS offers services to frail older adults or adults with disabilities, to restore or maintain their capacity for self-care and delay moving into an institutionalized setting. CBAS services include:

- An individual assessment
- Professional nursing services
- Therapeutic activities
- Social services
- Personal care
- One meal per day
- Physical, occupational and speech therapies as needed
- Mental health services as needed
- Nutrition services as needed
Transportation to and from the member’s residence and CBAS center as needed

To qualify for CBAS, members must meet the following eligibility requirements:

- Enrolled in CalOptima in the Medi-Cal or OneCare Connect programs
- Be at least 18 years of age or older
- Require Nursing Facility-A (NF-A) level of care or above, or
- Have an organic, acquired or traumatic brain injury or chronic mental health condition or
- Have moderate to severe cognitive disorder such as Alzheimer’s disease or other dementia or
- Have mild cognitive impairment or
- Have developmental disabilities that meet Regional Center eligibility criteria

CalOptima LTSS staff, contracted registered nurse, or Kaiser staff will perform a face-to-face (F2F) assessment of the member within 30 calendar days of receipt of the initial eligibility inquiry. CalOptima shall not require an initial F2F review when adequate documentation is available to make a determination that a member is eligible to receive CBAS. CalOptima LTSS clinical staff shall make CBAS eligibility determinations based on available clinical documentation. These include:

- History and physical
- Laboratory results
- Diagnostic reports
- Medication profiles
- Facility discharge summary
- PCP or specialist progress notes

Grievances and Appeals

If a member does not meet CBAS eligibility criteria, CalOptima will deny the request and notify the member of the denial decision in writing through use of the Notice of Action or Integrated Notice of Denial that addresses member's right to file an appeal or grievance under state and federal law.

CBAS Authorization Process

CBAS centers must submit the following documentation via facsimile to the CalOptima LTSS department:

- The completed CalOptima CBAS Authorization Request Form (ARF) to include the following information:
  a. A start and end date
  b. Total number of days requested per week
  c. Total number of days requested in a six month period
  d. The member's individualized plan of care
- An authorization is required before a member initially attends CBAS and every six months thereafter.

CONTACT INFORMATION

For more information from CalOptima for CBAS services, please contact the Long-Term Support Services department at 714-246-8444. Providers may also access GG.1130: Community-Based Adult Services (CBAS) Eligibility and Authorization Process available at www.caloptima.org/.

CalOptima Policies and Procedures:
GG.1130: Community-Based Adult Services (CBAS) Eligibility and Authorization Process

Section C: Covered Services
C7: PEDIATRIC PREVENTIVE SERVICES

CalOptima is directly responsible for paying providers for Medi-Cal services covered under the Child Health and Disability Prevention (CHDP) program. CalOptima refers to this program as the Pediatric Preventive Services (PPS) Program. CalOptima’s PPS program follows the American Academy of Pediatrics (AAP) guidelines, which cover 14 additional regular preventive health assessments over and above those covered by the CHDP program. The PPS program covers members from birth up to 21 years of age. A health assessment includes, but is not limited to the following:

- Health and developmental history
- Physical examination
- Nutritional assessment
- Immunizations
- Vision testing
- Hearing testing
- Selected laboratory tests
- Health education
- Anticipatory guidance

To review the full AAP guidelines, please access the Providers section of CalOptima’s website. CalOptima pays providers for PPS services on a fee-for-service basis.

Exceptions: Please note that school districts, public health care agencies and laboratories can still bill for PPS services without a contractual relationship with CalOptima.

PPS PROVIDER PARTICIPATION REQUIREMENTS

To participate in the PPS program, providers must meet all of the requirements below:

1. Providers must be registered with the Department of Health Care Services (DHCS).
   a. **Department of Health Care Services (DHCS)** — Providers and medical groups must register their National Provider Identifier (NPI) number with the DHCS for each service location to be registered with the CalOptima program. For information on registering with the DHCS, please contact DHCS Provider Enrollment Department (PED) at 916-323-1945, or go to the DHCS website at [www.dhcs.ca.gov](http://www.dhcs.ca.gov).

2. Providers must follow the American Academy of Pediatrics (AAP) guidelines.

3. Providers must complete the Staying Healthy Assessment tool at the appropriate age intervals. The Staying Healthy Assessment tool may be obtained in the Provider section of CalOptima’s website. Physicians must participate in the Vaccines for Children (VFC) program. Providers are not required to be CHDP certified or be Board certified to participate in the VFC program. For more information, please call the VFC program at 877-243-8832 or visit their website at: [Vaccines for Children Program](http://www.vfcprogram.org).
BILLING FOR PPS SERVICES

1. Use the PM160 Informational Only Form (brown form) to document all PPS services provided and to submit as a billing form for payment of services for dates of service through June 30, 2018. For dates of service on or after July 1, 2018, the PM160 Information Only form will no longer be accepted and providers must use the CMS1500 or UB04 claim form for all preventive services.

2. For CalOptima members, providers should send their claims to:
   
   CalOptima  
P.O. Box 11037  
Orange, CA 92856

3. For patients NOT ELIGIBLE for CalOptima, **CHDP certified providers** should send their PM160 (green form) directly to:
   
   Medi-Cal/CHDP  
P.O. Box 15300  
Sacramento, CA 95851-1300

4. Providers are paid on a fee-for-service basis, according to the Pediatric Preventive Services Schedule of Maximum Allowances.

5. CalOptima only pays the administration fee for each vaccine supplied by the VFC Program.

6. For instructions on how to complete a PM160 INF claim form please refer to the Providers section of CalOptima’s website.

**CalOptima Policies and Procedures:**

GG.1116: Pediatric Preventive Services
C8: PERINATAL SUPPORT SERVICES

Perinatal Support Services (PSS) is a special program provided by CalOptima for pregnant women. PPS are provided to pregnant members through pregnancy and for at least 60 days postpartum, including:

- Nutrition, health education, psychosocial assessments and other interventions
- Referrals to the Women, Infant, and Children (WIC) program, DHCS-approved genetic diagnosis centers (if necessary), dental services and other services as needed
- Information about breastfeeding
- Evaluation and reporting of suspected domestic abuse
- Other information about prenatal care or services

CalOptima relies upon its providers to refer pregnant women to the PSS program by submitting a Pregnancy Notification Report (PNR) form to CalOptima’s Case Management department within five calendar days after a member’s first obstetric visit. CalOptima refers all pregnant members to Maternal Outreach Management Systems (MOMS) for all PPS.

1. To obtain a copy of the PNR form, please visit the Providers section of CalOptima’s website.
2. Providers should fax the completed PNR to the CalOptima Case Management department at: 714-246-8677.
3. To obtain more information about the PSS program, please call CalOptima’s Case Management department at 714-246-8686.

CalOptima Policies and Procedures:
GG.1701: CalOptima Perinatal Support Services Program
C9: Vision Services

This section applies to the following CalOptima programs:

- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

C9: VISION SERVICES

In general, Medi-Cal covers the following vision services:

- One routine eye exam with refraction every 24 months, with a second eye exam with refraction when medically necessary
- Eye appliances when prescribed by a physician or optometrist, including prescription eyeglasses, eyeglass frames, contact lenses (when medically necessary), low vision aids (excluding electronic devices) and prosthetic eyes

CalOptima covers optometry services for the following types of Medi-Cal members:

- Members who have full-scope Medi-Cal benefits and who are under age 21
- Members who are residents of a nursing facility
- Members whose course of treatment began prior to July 1, 2009, and continues after July 1, 2009
- Members receiving services due to a condition that might complicate a pregnancy
- Members receiving optometry services in a hospital outpatient department

OneCare (HMO SNP) and OneCare Connect covers additional vision services beyond those normally provided under original Medicare. These services typically include routine eye exams, as well as eyewear coverage.

For more information on vision services covered by OneCare (HMO SNP) or OneCare Connect, please see the OneCare (HMO SNP) or OneCare Connect Summary of Benefits located in the OneCare (HMO SNP) and OneCare Connect member sections of CalOptima’s website.

CalOptima contracts with VSP Vision Care to provide vision services to all CalOptima Medi-Cal, OneCare (HMO SNP) and OneCare Connect members, except those enrolled in the Kaiser health network, which provides vision services for members enrolled in their health network.

To refer a member to VSP for vision services, or for questions about coverage, please call VSP at: 800-615-1883.

CalOptima Policies and Procedures:

GG.1111: Vision Services
C10: BEHAVIORAL HEALTH SERVICES

MEDI-CAL

Outpatient Behavioral Health Services

CalOptima is responsible for outpatient behavioral health services for Medi-Cal members who have mild to moderate impairments resulting from a mental health condition. CalOptima directly manages the Medi-Cal behavioral health benefits. A behavioral health provider must contract with CalOptima to provide Medi-Cal behavioral health services. Available services include:

- Outpatient psychotherapy (individual and group therapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include lab work, drugs and supplies
- Outpatient services for the purposes of monitoring drug therapy
- Psychiatric consultation

When members are determined to have a level of impairment other than mild to moderate, they will receive services directly from the Orange County Mental Health Plan (MHP) through the Orange County Health Care Agency (HCA) or community-based organizations. MHP retains the responsibility for specialty mental health services, which include psychiatric inpatient hospital services. Drug Medi-Cal services are also available through the HCA.

Behavioral Health Services at Long-Term Care Facilities

Medi-Cal beneficiaries receiving services under long-term care (LTC) are eligible for behavioral health services covered by CalOptima. These services are for the treatment of mild to moderate behavioral health conditions. To assist a CalOptima member residing in an LTC facility access behavioral health services for mild to moderate conditions, the nursing facility can call CalOptima Behavioral Health at 855-877-3885. CalOptima will assist the facility in determining eligibility and identifying treatment needs.

If the member qualifies for specialty mental health services, the member might be eligible for psychiatric consultation (with prior authorization) covered by the MHP.

Behavioral Health Treatment for

CalOptima covers behavioral health treatment (BHT) services include applied behavioral analysis (ABA) and other evidence-based services. A CalOptima Medi-Cal member may qualify for BHT services if the member:

- Is under 21 years of age
- Has behaviors that effect quality of life
- Has a recommendation for services from a licensed physician, surgeon or psychologist.
- Has documented evidence that BHT services are medically necessary
- Is medically stable without need for 24-hour medical/nursing monitoring or procedures provided in hospital or intermediate care facility for person with intellectual disabilities (ICF/ID)
Prior Authorization

Medi-Cal outpatient behavioral health services do not require prior authorization except for psychological testing. BHT services also require prior authorization before commencing services.

To request authorization for services, providers must complete and submit the Behavioral Health Authorization Request Form (BH-ARF) and fax it to the Utilization Management department for review and decision at: 714-954-2300.

ONECARE (HMO SNP)

Behavioral health services are a covered benefit for OneCare dually eligible Medi-Cal/Medicare members. CalOptima has partnered with Magellan, a behavioral health management company, to administer OneCare’s behavioral health benefits. A contracted Magellan provider must provide OneCare behavioral health services.

ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN)

OneCare Connect members have access to behavioral health services currently covered by Medicare and Medi-Cal. CalOptima has partnered with Magellan to administer OneCare Connect's behavioral health benefits. Behavioral health services include inpatient and outpatient care, integrated with medical care and services:

- Inpatient services (general acute, emergency services)
- Partial hospitalization/intensive outpatient
- Psychological testing
- Psychiatric office visits
- Outpatient psychotherapy (individual and group therapy)

Magellan coordinates services for members identified with mild to moderate behavioral health needs. Magellan refers members identified for higher level of care or specialty mental health services to the MHP. A member may also self-refer for MHP services.

HOW TO MAKE A BEHAVIORAL HEALTH SERVICES REFERRAL

Medi-Cal

To refer a CalOptima Medi-Cal member for outpatient behavioral health services, call CalOptima Behavioral Health at 855-877-3885 and choose the Medi-Cal option. Members will be connected to a CalOptima representative. The member will be screened for level of impairment to determine appropriate services. Members will either be provided with referrals to CalOptima contracted behavioral health providers or directed to another level of care including MHP. This line is available 24 hours a day, seven days a week. TDD/TTY users can call 800-735-2929.

To refer a CalOptima Medi-Cal member for specialty mental health services, call the MHP Access Line at 800-723-8641. This line is available 24 hours a day, seven days a week.

To have a CalOptima Medi-Cal member evaluated for a psychiatric emergency, which might include inpatient mental health services, call Orange County Crisis Stabilization Unit (CSU) at 714-834-6900 or Centralized Assessment Team (CAT) at 866-830-6011.

OneCare

To refer a OneCare member for routine or urgent behavioral health services, call CalOptima Behavioral Health Line at 855-877-3885 and choose the OneCare option. The member will be connected to a Magellan
representative to assist the member in obtaining appropriate services. The member will be screened for level of impairment to determine appropriate services. Members will either be provided with referrals to Magellan contracted behavioral health providers or directed to another level of care including MHP. The line is available 24 hours a day, seven days a week. TDD/TTY users can call 800-735-2929.

To refer a CalOptima OneCare member for specialty mental health services, call the MHP Access Line at 800-723-8641. This line is available 24 hours a day, seven days a week.

To have a CalOptima OneCare member evaluated for a psychiatric emergency, which might include inpatient mental health services, call Orange County Crisis Stabilization Unit (CSU) at 714-834-6900 or Centralized Assessment Team (CAT) at 866-830-6011.

**OneCare Connect**

To refer a OneCare Connect member for routine or urgent behavioral health services, call CalOptima Behavioral Health Line at 855-877-3885 and choose the OneCare Connect option. The member will be connected to a Magellan representative to assist the member in obtaining appropriate services. The member will be screened for level of impairment to determine appropriate services. Members will either be provided with referrals to Magellan contracted behavioral health providers or directed to another level of care including MHP. The line is available 24 hours a day, seven days a week. TDD/TTY users can call 800-735-2929.

To refer a CalOptima OneCare Connect member for specialty mental health services, call the MHP Access Line at 800-723-8641. This line is available 24 hours a day, seven days a week.

To have a CalOptima OneCare Connect member evaluated for a psychiatric emergency, which might include inpatient mental health services, call Orange County Crisis Stabilization Unit (CSU) at 714-834-6900 or Centralized Assessment Team (CAT) at 866-830-6011.

**HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES**

Both the member’s primary care provider (PCP) and behavioral health provider can make referrals to alcohol and drug abuse services. See Section C11 for details.

**QUESTIONS FROM BEHAVIORAL HEALTH PROVIDERS**

**Medi-Cal**

Behavioral health providers who have questions about contracting, claims processing, open referrals or other administrative issues for the Medi-Cal program, contact:

- CalOptima Provider line at: **714-246-8600**
- Magellan Provider line at: **800-430-0535** (Date of service year in 2017)

**OneCare**

Behavioral health providers who have questions about contracting, claims processing, open referral or other administrative issues for the OneCare program, contact:

- Magellan Provider line at: **800-430-0535**

**OneCare Connect**
Behavioral health providers who have questions about contracting, claims processing, open referral or other administrative issues for the OneCare Connect program, contact:

- Magellan Provider line at: **800-430-0535**

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<td>CMC.6033: Assessment, Referral, Coordination and Information Sharing for Cal MediConnect Members</td>
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<td>GG. 1549: Authorization for Psychological Testing for Mental Health Conditions</td>
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</tbody>
</table>
C11: DRUG AND ALCOHOL ABUSE SERVICES

Alcohol and drug abuse services are a covered benefit for CalOptima Medi-Cal members, although these services are administered by the Orange County Health Care Agency (OC HCA) and not by CalOptima or its health networks.

OC HCA’s Alcohol and Drug Abuse Services provides a range of outpatient and residential treatment programs designed to reduce or eliminate the abuse of alcohol and other drugs within the community.

Services include crisis intervention, assessment and evaluation, individual, group and family counseling, HIV education, pre- and post-test counseling, voluntary testing, tuberculosis education, counseling and testing, referrals to other programs when indicated, and outreach to schools and the general community. Specialized programs provide services for pregnant and parenting women, persons who require methadone maintenance and detoxification, adolescents and persons who have been dually diagnosed with substance abuse and mental health problems, and individuals referred by the Orange County Drug Court.

The Risk Reduction, Education and Community Health (REACH) Program (formerly AIDS Outreach Project) provides HIV/AIDS education and outreach to the community, including street outreach to addicts who are not in treatment and who are at high risk for contracting and transmitting HIV, tuberculosis and other communicable diseases.

With the expansion of Medi-Cal services, providers are responsible to conduct the Alcohol Misuse Screening and Counseling (AMSC) process. This was updated from the Screening Brief Intervention Referral and Treatment (SBIRT) in October 2017 when DHCS announced updated requirements for alcohol misuse screening.

Alcohol Misuse Screening and Counseling (AMSC)

When a member answers “yes” to the Individual Health Education Behavior Assessment (IHEBA) alcohol prescreen question, the primary care provider (PCP) should conduct an expanded screening using a validated alcohol screening questionnaire. If the member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified, the PCP should offer behavioral counseling intervention to the member. Members who, upon screening and evaluation, meet criteria for an alcohol use disorder or whose diagnosis is uncertain should be referred for further evaluation and treatment.

For more information regarding the AMSC, please visit the Providers section of CalOptima’s website underneath the Provider FAQs tab and then Behavioral Health.

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

To refer a member for alcohol and substance use disorder treatment services, visit the OC HCA website at http://www.ochealthinfo.com or call 800-723-8641. OC HCA’s Alcohol and Drug Abuse Services operates a network of clinics to deliver services. OC HCA’s Alcohol and Drug Abuse Outpatient Clinic section of their website provides phone numbers and addresses for clinics to which members may be referred.

CalOptima Policies and Procedures:
GG.1100: Alcohol and Substance Abuse Treatment Services
D1: AIDS WAIVER SERVICES REFERRAL

The Medi-Cal AIDS Waiver Program provides home- and community-based services to persons with HIV/AIDS in their home rather than in a hospital or a nursing facility. Members with HIV can use this service to help them stay at home or to return to their home from a facility.

Who Qualifies for the Program? To qualify, members must have a written diagnosis by an attending physician of HIV or AIDS, with concurrent signs, symptoms or disabilities related to the HIV virus or treatment. In addition, members must also meet the following criteria including, but not limited to:

- Be an eligible Medi-Cal recipient on the date of enrollment.
- Have a written diagnosis from his/her attending physician of HIV or AIDS with current signs, symptoms or disabilities related to HIV virus or HIV disease treatment.
- Be certified by a nurse case manager to be at the nursing facility level of care using the Cognitive and Functional Ability Scale assessment tool.
- Must not be simultaneously enrolled in Medi-Cal Hospice (may be simultaneously enrolled in Medicare Hospice).
- Must not be simultaneously enrolled in the AIDS Case Management Program.
- If the member is a child under age 13, be certified by a nurse case manager as HIV/AIDS symptomatic.
- Have an attending primary care provider willing to accept full professional responsibility for the recipient’s medical care.
- Have a health status consistent with in-home services and have a home setting that is safe for both the member and service providers.

WHAT SERVICES ARE PROVIDED UNDER THE WAIVER?

Types of services typically include:

- Case management
- Homemaker services
- Minor physical adaptations to the home
- In-home skilled nursing care (registered nurse and licensed vocational nurse)
- Medi-Cal supplement for infants and children in foster care
- Specialized medical equipment and supplies
- Attendant care
- Psychotherapy
- Non-emergency medical transportation
- Home-delivered meals
- Nutritional counseling
- Nutritional supplements

Neither CalOptima nor its health networks are responsible for the provision of payment of AIDS Waiver services.
HOW TO REFER A PATIENT TO THE AIDS WAIVER PROGRAM

To refer a member to the AIDS Waiver Services Program in Orange County, contact the AIDS Services Foundation of Orange County at 949-809-5700.
D2: Drug and Alcohol Abuse Services

This section applies to the following CalOptima programs:

Medi-Cal

D2: DRUG AND ALCOHOL ABUSE SERVICES

Alcohol and drug abuse services are a covered benefit for CalOptima Medi-Cal members, although these services are administered by the Orange County Health Care Agency (HCA), and not by CalOptima or its health networks.

HCA’s Alcohol and Drug Abuse Services provides a range of outpatient and residential treatment programs designed to reduce or eliminate the abuse of alcohol and other drugs within the community.

Services include: crisis intervention, assessment and evaluation; individual, group and family counseling; HIV education; pre- and post-test counseling; voluntary testing; tuberculosis education, counseling and testing; referrals to other programs when indicated; and outreach to schools and the general community. Specialized programs provide services for pregnant and parenting women, persons who require methadone maintenance and detoxification, adolescents and persons who have been dually diagnosed with substance abuse and mental health problems, and individuals referred by the Orange County Drug Court.

The Risk Reduction, Education and Community Health (REACH) Program (formerly AIDS Outreach Project) provides HIV/AIDS education and outreach to the community, including street outreach to addicts who are not in treatment and who are at high risk for contracting and transmitting HIV, tuberculosis and other communicable diseases.

ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)

When a member answers “yes” to the Individual Health Education Behavior Assessment (IHEBA) alcohol pre-screen question, PCP should conduct an expanded screening using a validated alcohol screening questionnaire. If the member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified, the PCP should offer behavioral counseling interventions to the member. Members who, upon screening and evaluation, meet criteria for an alcohol use disorder or whose diagnosis is uncertain, should be referred for further evaluation and treatment.

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

For more information regarding the AMSC, please visit the Providers section of CalOptima’s website. To refer a member for alcohol and substance use disorder treatment services, please visit the HCA website at http://www.ochealthinfo.com or call 800-723-8641. HCA’s Alcohol and Drug Abuse Services operates a network of clinics to deliver services. HCA’s Alcohol and Drug Abuse Outpatient Clinic section of their website provides phone numbers and addresses for clinics to which members may be referred.

CalOptima Policies and Procedures:

GG.1100: Alcohol and Substance Abuse Treatment Services
D3: CALIFORNIA CHILDREN’S SERVICES

The California Children’s Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and is administered in Orange County by the Orange County Health Care Agency’s CCS office.

CCS provides health care services including diagnostic, treatment, dental, medical case management, physical and occupational therapy services, and financial assistance to CalOptima members under age 21 who live in Orange County and who meet the eligibility requirements to receive services. If a provider thinks that one of their members has a medical condition that CCS covers, CCS may pay for an exam to see if CCS will cover the member’s problem.

CCS Services — CalOptima Medi-Cal members qualifying for CCS may receive additional services, including:

- Treatment services to confirm a CCS-eligible condition and provide medically necessary care and case management services
- Medications, equipment and medical supplies
- Medical therapy program, which provides medically necessary physical therapy, occupational therapy, and medical therapy conference services
- High-risk infant follow-up program, which provides follow-up services to infants discharged from a CCS neonatal intensive care unit and who are at risk of developing a CCS-eligible condition
- Human Immunodeficiency Virus (HIV) children’s screening, which provides a structured system for screening/monitoring infants and children at risk for HIV infection

What else can CCS do for a member?

CCS can manage the member’s medical care, meaning CCS can provide the special doctors and care that the member needs. Sometimes CCS refers members to other agencies, such as public health nursing and regional centers, in order for the member to receive the services they need. CCS also has a Medical Therapy Program (MTP). MTPs are in public schools and provide physical and occupational therapy to eligible children.

Identifying Patients Potentially Eligible for CCS — To be eligible for CCS, CalOptima members must be diagnosed with a CCS-qualifying condition, which includes, but is not limited to:

- Congenital heart disease
- Chronic renal disease
- Malignant neoplasms (including leukemia)
- Hemophilia and other coagulopathies
- Endocrine disorders (including diabetes)
- Organ transplant candidates
- Major trauma
- Serious chronic kidney problems
- Liver or intestine diseases
- Hearing loss, cataracts
- Rheumatoid arthritis, muscular dystrophy
- Severely crooked teeth
- Cancer, tumors
- Chronic lung disease
- Cranofacial anomalies
- Mylomeningocele
- AIDS
- Prematurity
- Inherited metabolic disorder
- Thyroid problems, diabetes
- Cleft lip/palate, spina bifida
- Cerebral palsy, uncontrolled seizures
- Severe head, brain or spinal cord injuries
- Broken bones

For an overview of CCS general medical eligibility criteria, please visit the California Department of Health Care Services (DHCS) website by clicking here: CCS Eligibility, or the County of Orange website by clicking here: California Children's Services

Please note that if you determine that a member may have a CCS-eligible condition, you must refer the member to CCS within 24 hours or by the next working day.

HOW TO MAKE A REFERRAL TO CCS

To refer a CalOptima member to CCS, providers can call the Orange County CCS Office at 714-347-0300 to obtain a CCS referral form, or download a copy of the form on the Department of Health Care Services (DHCS) website by clicking here: DHCS — California Children's Services

Providers have four CCS Service Authorization Request (SAR) forms they may use to refer members for CCS services:

- CCS Client Dental and Orthodontic SAR
- New Referral SAR
- Established Client SAR
- Discharge Planning SAR

Complete the appropriate form and mail it to:

CCS
200 W. Santa Ana Blvd., Suite 100
Santa Ana, CA 92701

For emergent cases, fax the referral form to: 714-347-0301.

HELPFUL INFORMATION FOR AUTHORIZATION PROCESS

- Providers should verify CCS eligibility before submitting the SAR.
- Providers must submit the request using the SAR form.
- Providers are required to submit documentation to substantiate medical necessity at the time the SAR is submitted.
- The completed SAR form with the supporting documentation may be submitted to the appropriate CCS county or regional office via fax or mail. Examples of supporting documentation include prescriptions, clinic visit reports, physical therapy evaluation reports, etc. A SAR without supporting documentation will be deferred back to the provider for additional information.
- Each SAR submitted to CCS is reviewed for medical necessity.
If the SAR is approved, a copy of the authorization letter will be sent to the provider and family via fax or email. If the SAR is denied, a copy of the Notice of Action (NOA) or denial letter with the reason for denial of service will be sent to the member, parent or legal guardian with a courtesy copy to the provider via mail. If the SAR is incomplete and lacks supporting documentation to substantiate medical necessity, CCS will request the provider submit additional information. There will be no further action on the SAR until CCS receives the requested information.

When making the referral, please keep in mind that the child must use a CCS paneled provider to receive CCS covered services.

**CONTINUITY OF CARE**

- CalOptima primary care providers must continue to provide all medically necessary covered services to the member until CCS eligibility is confirmed.
- Once eligibility has been established for the member, CalOptima primary care providers shall continue to provide all medically necessary covered services that are not authorized by CCS and shall work with CalOptima, CCS specialty providers and the local CCS program to ensure coordination of services and combined case management.
- If the local CCS program does not approve eligibility for the member, CalOptima remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, CalOptima remains responsible for obtaining the service and, if medically necessary, paying for the service if it has been provided.

**HOW TO AVOID DENIALS FOR CCS SERVICES**

The CCS program requires prior authorization for services. This means that a Service Authorization Request (SAR) must be submitted to the CCS state office for approval for all diagnostic and treatment services, excepting emergencies. Authorization request for emergency services must be submitted to CCS by the close of the next business day following the date of service.

**HOW TO BECOME A CCS PROVIDER**

- In order to become a provider for CCS, providers can submit a CCS panel application online to the link: [Children’s Medical Services](#).
- Providers may track their application status online with a unique tracking number. In addition, providers will receive an immediate online approval or request for any additional documentation necessary to process their pending applications.

**CLAIMS INFORMATION**

- CCS claims are not adjudicated by CCS; all claims are processed through Xerox, the state fiscal intermediary. Providers may submit their claims directly to the State of California Fiscal Intermediary at the following address:

  Xerox State Healthcare LLC  
P.O. Box 15700  
Sacramento, CA 92852-1700

- Use BIN# 610442; otherwise, the claim will deny.
If providers have questions regarding their claim, they may contact the Xerox Telephone Service Center (TSC) at 800-541-5555.
If providers need further assistance, they can obtain a ticket number from TSC and request a review of the claim with provider staff; the representative can offer an office visit, as needed.
Providers are encouraged to attend the Medi-Cal Provider Trainings, which are offered on a regular basis throughout the state. Dates and locations of training are available on the Medi-Cal website at: Medi-Cal Training Calendar.

Payment for CCS Services — Only providers who have been approved by CCS are eligible for reimbursement under the CCS program. CCS reimbursement is separate from any funds received under the CalOptima program and is billed directly through the CCS program.

WHAT ARE SERVICE CODE GROUPINGS?
- Service Code Groupings (SCGs) are a group of reimbursable codes authorized to a provider under one Service Authorization Request (SAR) for the care of a CCS client.
- The SCGs allow providers to render multiple services for a CCS client without the submission of a separate SAR for each service needed by the member.

DENIED CLAIMS
- If a provider’s claim has been denied, review the Remittance Advice Detail (RAD). Correct your errors and resubmit your claim accordingly.
- If you have any questions, please call the Telephone Service Center (TSC) at 800-541-5555.
- If you need further assistance, obtain a ticket number from TSC and request their representative review the claims with you. The representative can arrange an office visit, as needed.
- Providers can also access billing tips for CCS on the Medi-Cal website by clicking on the following link: Billing Tips — California Children's Services

PRIOR AUTHORIZATIONS
- All services covered under the CCS program require prior authorization from CCS. In order to request services for a member, the provider must complete a Service Authorization Request (SAR). A completed SAR form, along with the relevant medical reports and prescriptions, can be faxed to the Orange County CCS Office at 714-347-0301 for processing.
- The SAR form is available for download on the Department of Health Care Services (DHCS) website, and can be accessed at: DHCS- California Children's Services

HOW TO VIEW AUTHORIZATIONS ONLINE
- Complete the Provider Electronic Data Interface (PEDI) application, which can be downloaded on the DHCS website at: Provider Electronic Data Interface (PEDI).
- Application package: Application packages must contain original signatures signed in blue ink and mailed to:

  Attn: Management Information Systems
  Department of Public Health
  Children’s Medical Services
  9320 Telstar Avenue, Suite 226
  El Monte, CA 91731
Pending, approved and denied SARs are viewable in real time.
Each user must have their own login and password.
Remember to include all National Provider Identifier (NPI) numbers associated with group NPIs and Special Care Center affiliations on the PEDI application so that all possible client SARs are accessible.

CHANGES OF PROVIDER ADDRESSES
- Enrolled providers are responsible for notifying DHCS within 35 days of the date of a change to their business and/or pay-to address.
- Go to the Forms section of the DHCS website for a copy of the Medi-Cal Supplemental Changes form (DHCS 6209) or a full enrollment package, whichever is applicable, and submit the completed forms to the address listed on the forms.
- When the address change has been made, the provider will be instructed by the Provider Enrollment Division (PED) how to request payments be re-issued to the provider, if necessary.
- Providers may contact the PED message center at 916-323-1945 if there are any questions about which forms are required to report your specific change.

DRUGS AND SUPPLIES REQUIRING SEPARATE AUTHORIZATION
Refer to the list of drugs that require a separate SAR located on the Medi-Cal website under “California Children’s Services (CCS) Program Service Authorization Request (SAR).” Providers may access the link on the Medi-Cal website at: CCS Program SAR

FOR MORE INFORMATION ON CCS
For more information about CCS, call 714-347-0300 (CalOptima providers only), or go to the Orange County CCS Office website at: California Children’s Services

CalOptima Policies and Procedures:
GG.1101: California Children’s Services
D4: DENTAL SERVICES

Denti-Cal covers dental services for the following types of Medi-Cal members:

- Members who have full-scope Medi-Cal benefits and who are under age 21
- Members who are residents of a skilled nursing facility (SNF)
- Members who are residents of an intermediate care facility (ICF)
- Dental services that are necessary as either a condition precedent to other medical treatment or in order to undergo a medical surgery
- Members whose course of treatment began prior to July 1, 2009, and continues after July 1, 2009
- Members receiving services due to a condition that might complicate a pregnancy
- Members receiving Federally Required Adult Dental Services (FRADS). For additional information on the Medi-Cal dental benefit, visit the Denti-Cal website at: Denti-Cal.

The current dental benefit is administered by the Denti-Cal program and not by CalOptima or its health networks. CalOptima’s health networks and CalOptima Direct are only responsible for providing selected dental-related procedures in certain circumstances, such as coverage of general anesthesia (when provided by non-dental personnel) for a dental procedure in a dental office, inpatient facility, accredited ambulatory surgery center or community health center.

Please note that Medi-Cal and Medicare (Medi-Medi) members enrolled in OneCare Connect will be able to receive dental benefits as part of their OneCare Connect benefit.

CalOptima providers can play a critical role in identifying dental-related issues and in referring members to appropriate dental providers. Most dental disease can be prevented, and dental inspection presents an opportunity to instruct members in proper hygiene procedures and to detect oral health problems.

MEDI-CAL DENTAL PROGRAM BENEFITS

The Medi-Cal Dental Program covers a variety of services such as:

- Exams and x-rays
- Cleanings (prophylaxis)
- Fluoride treatments
- Fillings
- Root canals in front teeth
- Prefabricated crowns
- Full dentures
- Other medically necessary dental services

HOW TO MAKE A DENTAL REFERRAL

1. To make a referral to the Denti-Cal program, call Denti-Cal at 800-322-6384, or go to the Denti-Cal website at: Denti-Cal. TDD/TTY users can call 800-735-2922.
2. All children with an active infection, pain or severe problems should be referred to the Denti-Cal program for immediate diagnosis and treatment by a dentist or oral health surgeon. Children with other dental problems should be referred within a reasonable period of time for diagnosis and treatment.
3. All children over age three should be referred to a dentist. Children over age three should have the benefit of definitive dental diagnosis, remedial treatment and should be seen by a dentist at least annually.

CalOptima Policies and Procedures:
GG.1504: Dental Services
D5: Dental Services for OneCare Connect Members

This section applies to the following CalOptima programs:

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

D5: DENTAL SERVICES

OneCare Connect offers dental services from Denti-Cal and supplemental benefits from LIBERTY Dental Plan at no additional cost. These dental services typically include preventive dental services and comprehensive dental treatment.

OneCare Connect members are assigned to a primary dentist who is responsible for providing his or her dental care. OneCare Connect members can change their primary dentist assignment on a monthly basis, effective the first day of the next month.

HOW TO MAKE A DENTAL REFERRAL

To make a dental referral, or to help a member identify his or her primary dentist, please contact Denti-Cal at 800-322-6384. TDD/TTY users should call 800-735-2922. For further information from LIBERTY Dental Plan, please call 888-704-9838. TDD/TTY users can call 800-735-2929.

For further information from CalOptima, please contact OneCare Connect at 855-705-8823, 24 hours a day, seven days a week, or visit the OneCare Connect member section of the CalOptima website. TDD/TTY users can call 800-735-2929.
This section applies to the following CalOptima programs:

- Medi-Cal,
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

D6: HOME- AND COMMUNITY-BASED SERVICES REFERRALS

Some CalOptima members may benefit from receiving home- and community-based services. These services are generally targeted toward the frail elderly, or persons with physical or developmental disabilities, and are intended to allow them to remain in their home and avoid unnecessary institutionalization.

**What are Home- and Community-Based Services?** Home- and community-based services depend on the needs of the member and may include:

- Case management
- Homemaker services
- Home health aide services
- Personal care services
- Habilitation services
- Respite
- Day treatment

**Who Might Benefit from Home- and Community-Based Services?** Members who might benefit from home- and community-based services typically include the elderly or persons with physical or developmental disabilities and members who are at risk of being placed in a nursing home.

Neither CalOptima nor its health networks are responsible for the provision or payment of Home- and Community-Based Services (HCBS).

**HOW TO REFER A PATIENT TO HOME AND COMMUNITY-BASED SERVICES**

If you have a member who qualifies for home- and community-based services, please call the CalOptima Case Management department at 714-246-8686.
D7: Regional Center of Orange County (RCOC) Services

This section applies to the following CalOptima programs:

Medi-Cal

D7: REGIONAL CENTER OF ORANGE COUNTY SERVICES

The Regional Center of Orange County (RCOC) is a not-for-profit agency under contract with the California Department of Developmental Services that provides support and care for persons with or at risk for developmental disabilities in Orange County.

Who is Eligible to Participate in RCOC?

- Any resident of Orange County who has or may have a developmental disability before 18 years of age is entitled to receive an assessment to determine eligibility.
- To be eligible for services, a person must have a disability that is substantially handicapping; examples include intellectual disability, epilepsy, cerebral palsy, autism, and disabling conditions found to be closely related to intellectual/cognitive disabling or to require treatment similar to that required for individuals with intellectual disabilities. The RCOC does not cover handicapping conditions that are solely physical in nature.
- Those individuals diagnosed with developmental disability, according to law, become “consumers” of RCOC and can receive continuing services.

What Types of Services are Available Through the RCOC?

Services are offered to consumers based upon individual program plans and may include:

- Case management and individual program planning
- Prenatal diagnostic evaluation
- Early intervention services (birth up to 36 months)
- Therapy services
- Residential services — group homes, independent and supported living services
- Respite care services
- Child care services
- Adult day program services (employment and community-based activities)
- Transportation services
- Psychological counseling and behavioral services
- Medical and dental services
- Equipment and supplies
- Social and recreational services

COORDINATION OF MEMBER CARE

CalOptima or the member’s health network shall designate a community liaison or case manager to serve as a liaison to RCOC to help coordinate care with RCOC, as needed.

HOW TO REFER A MEMBER TO THE RCOC

Providers who believe that a patient should be referred to the RCOC, should contact the RCOC offices by calling 714-796-5100. To obtain more information, visit RCOC’s website at: www.rcocdd.com/.
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<td>GG.1302a: Coordination of Care for Regional Center of Orange County</td>
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</table>
E1: VERIFYING MEMBER ELIGIBILITY

Except for emergency services, providers rendering covered services to any CalOptima member should first verify eligibility prior to rendering the service. CalOptima does not require a provider to verify a member’s eligibility prior to rendering emergency services. Verifying the member’s eligibility is critical to determine whether a member’s enrollment status has changed and to help ensure payment. A membership card does not guarantee eligibility.

HOW TO VERIFY MEMBER ELIGIBILITY

CalOptima’s Eligibility Verification Systems — CalOptima maintains a CalOptima Link and an Interactive Voice Response (IVR) System for verifying member eligibility. Providers may use these systems to verify a member’s Medi-Cal, OneCare (HMO SNP) or OneCare Connect eligibility.

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<th>CalOptima’s Eligibility Verification Systems</th>
<th>Description</th>
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<tr>
<td>CalOptima Link</td>
<td>CalOptima allows providers to obtain eligibility information online through CalOptima Link at <a href="http://www.caloptima.org">www.caloptima.org</a> for all CalOptima members. CalOptima Link provides the member’s assigned health network and primary care provider. Providers must be registered with CalOptima in order to utilize this service. Providers may register via the Providers tab on the CalOptima website.</td>
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<tr>
<td>CalOptima’s Interactive Voice Response (IVR) System</td>
<td>Providers may call the Interactive Voice Response (IVR) System to obtain answers to routine eligibility inquiries for all CalOptima members. The IVR provides the member’s assigned health network and primary care provider. To access CalOptima’s IVR system, providers may call 800-463-0935 or 714-246-8540. Enter the member’s 9-digit Client Identification Number (CIN), and use the letters below for the following numbers: A press 1 C press 2 D press 3 E press 4 K press 5 F press 6</td>
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### State Eligibility Verification Systems

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<tr>
<th>State Eligibility Verification Systems</th>
<th>Description</th>
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<tr>
<td>Automated Eligibility Verification Systems (AEVS)</td>
<td>This system returns a Medi-Cal Eligibility Verification Confirmation number (EVC). The Automated Eligibility Verification System (AEVS) is accessible by calling 800-456-2387.</td>
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<tr>
<td>Point of Service (POS) Device</td>
<td>This device offers a hard copy printout of the member’s Medi-Cal eligibility as confirmation. This printout can be used for documentation should a discrepancy arise regarding a member’s Medi-Cal eligibility.</td>
</tr>
<tr>
<td>Medi-Cal Website</td>
<td>Providers may verify Medi-Cal eligibility on the Medi-Cal website at: <a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov</a> Providers must have a Personal Identification Number (PIN) to access this system. The PIN is provided by Medi-Cal at the time when a provider registers his or her National Provider Identification number with Medi-Cal. If providers do not have a PIN, they may contact the POS Help Desk at 800-541-5555.</td>
</tr>
</tbody>
</table>

Providers should be mindful of the following rules and guidelines regarding eligibility verification:

- Always verify member eligibility prior to providing services.
- In emergency situations, check eligibility as soon as possible.
- For cases involving retroactive eligibility, a retro-authorization is due within 60 calendar days after the member’s retroactive eligibility is available in the state’s Automated Eligibility Verification System.
- If a member is not eligible for benefits on the date of service, then providers will not be paid by CalOptima or its health networks.

**CalOptima Policies and Procedures:**

DD.2003: Member Identification and Eligibility Verification
This section applies to the following CalOptima programs:

Medi-Cal

**E2: MEDI-CAL RECIPIENTS NOT ENROLLED IN CALOPTIMA**

The Department of Health Care Services (DHCS) enrolls most, but not all, Medi-Cal beneficiaries residing in Orange County into CalOptima. However, several types of Medi-Cal beneficiaries in Orange County remain in the Medi-Cal fee-for-service program and are not the responsibility of CalOptima. These beneficiaries include certain undocumented aliens who qualify only for restricted and or emergency services, and other types of beneficiaries with certain limited benefits.

**HOW TO IDENTIFY WHETHER MEDI-CAL RECIPIENTS ARE ENROLLED IN CALOPTIMA**

Providers can identify Medi-Cal beneficiaries enrolled in CalOptima through the state eligibility verification systems, including using the State Automated Eligibility Verification System (AEVS), the Point-of-Service (POS) device system, and the Medi-Cal website.

- **Beneficiary Is Medi-Cal Eligible and Enrolled in CalOptima** — For these recipients the state systems will reference the beneficiary as “Medi-Cal Eligible” and indicate “Health Plan Member: CalOptima.” The state system will also display “Health Care Plan: CalOptima” or the name of the member’s CalOptima health network if the member is enrolled in a health network.

- **Beneficiary Is Medi-Cal Eligible but Not Enrolled in CalOptima** — For these recipients, the state systems will reference the beneficiary as: “Medi-Cal Eligible,” but it will not include a “Health Plan Member” or “HCP” statement. This indicates that the beneficiary is not enrolled in CalOptima and remains in the Medi-Cal fee-for-service program. Providers should submit bills for Medi-Cal covered services furnished to these beneficiaries directly to the Medi-Cal fee-for-service program.

- **Beneficiary Is Not Medi-Cal Eligible** — If a person is not eligible for Medi-Cal benefits, the state systems will display the following message: “No Recorded Eligibility for (the date of service).”

**Aid Code Listing** — To obtain a copy of the Aid Code Listing that references the aid codes included in CalOptima, and the aid codes that are straight Medi-Cal members and claims billed directly to Medi-Cal, click here: Aid Codes

For more information on how to bill the DHCS Medi-Cal fee-for-service program, please visit: www.dhcs.ca.gov/
This section applies to the following CalOptima programs:
Medi-Cal, OneCare (HMO SNP),
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

E3: CALOPTIMA’S MEDI-CAL, ONECARE (HMO SNP) AND ONECARE CONNECT MEMBER ID CARD

CalOptima Medi-Cal ID Card: CalOptima issues each Medi-Cal member an identification card upon enrollment. The CalOptima member ID card is used to help identify the member, and is NOT proof of member eligibility. The card will include the member’s health network. All members receive this card from CalOptima.

Medi-Cal Benefits Identification Card (BIC): This card shows the provider that the member has Medi-Cal; all Medi-Cal beneficiaries receive this card from the state.

Sample CalOptima Medi-Cal ID Card

Sample Medi-Cal BIC Card

IMPORTANT TIPS ABOUT THE MEMBER ID CARD

The CalOptima Medi-Cal member ID card contains the following information:

- Front of the card:
  a. Member’s name and Client Identification Number (CIN)
  b. Member’s date of birth
  c. Member’s effective date
  d. Member’s health network and the health network’s phone number
  e. Phone numbers for both pharmacy and vision services (card can be used for pharmacy and vision services)

- Back of the card:
  a. Instructions for the member in the event of an emergency
  b. Member eligibility verification phone number (providers only): 714-246-8540
  c. CalOptima Provider Resource Line: 714-246-8600
  d. CalOptima Customer Service Line (members only): 888-587-8088 or TDD/TTY 1-800-735-2929

Upon presentation of the CalOptima member ID card, a provider can verify the member’s eligibility by using CalOptima Link located in the Provider section of CalOptima’s website or by calling CalOptima’s Interactive
Voice Response (IVR) line at 714-246-8540 or 800-463-0935. For more information on verifying a member’s eligibility, see Section E1: Verifying Member Eligibility.

**ONECARE MEMBER ID CARD**

OneCare (HMO SNP) issues each member an identification card upon enrollment. The member ID card is used to help identify the member, and is NOT proof of member eligibility.

![Sample CalOptima OneCare Member ID Card](image)

**IMPORTANT TIPS ABOUT THE MEMBER ID CARD**

The OneCare member ID card contains the following information:

- **Front of the card:**
  - Member’s name
  - Member’s ID number
  - Member’s health plan number
  - Member’s date of birth
  - Member’s effective date
  - Member’s primary care provider (PCP) name
  - Phone number of member’s PCP
  - Member’s health network
  - Phone number of member’s health network
  - Member’s pharmacy information (RxBIN, RxPCN, and RxGroup)

- **Back of the card:**
  - Important contact numbers
  - Claim submission information

Upon presentation of the OneCare member ID card, a provider can verify the member’s eligibility by using CalOptima Link located on CalOptima’s website or by calling CalOptima’s Interactive Voice Response (IVR) line at 714-246-8540 or 800-463-0935. For more information on verifying a member’s eligibility, please see Section E1: Verifying Member Eligibility.
ONECARE CONNECT MEMBER ID CARD

OneCare Connect members receive one card for Medicare and Medi-Cal services, including long-term supports and services, certain behavioral health services, and prescriptions. Members must show this card when they receive any services or prescriptions.

Sample OneCare Connect Member ID Card

IMPORTANT TIPS ABOUT ONECARE CONNECT MEMBER ID CARD

The OneCare Connect member ID card contains the following information:

- **Front of card:**
  - Member’s name
  - Member’s ID number
  - Member’s date of birth
  - Name of member’s PCP
  - Phone number of member’s PCP
  - Member’s health network
  - Phone number of member’s health network
  - Member’s health plan number
  - Member’s effective date
  - Member’s pharmacy information (RxBIN, RxPCN, and RxGroup)

- **Back of card:**
  - Important contact numbers
  - Claim submission information

Upon presentation of the CalOptima OneCare Connect member ID card, a provider can verify the member’s eligibility by using CalOptima Link located in the Provider section of CalOptima’s website or by calling CalOptima’s Interactive Voice Response (IVR) line at 714-246-8540 or 800-463-0935. For more information on verifying a member’s eligibility, see Section E1: Verifying Member Eligibility.
**E4: MEDI-CAL SHARE OF COST MEMBERS**

The Department of Health Care Services has a Share of Cost program to assist beneficiaries who may have **too much income** to qualify for traditional Medi-Cal. CalOptima members with a Medi-Cal share of cost must satisfy their monthly share of cost amount before they can access Medi-Cal covered benefits during the month(s) in which they satisfy their share of cost.

The monthly share-of-cost is a pre-determined amount that a member must pay each month for medical expenses. Members with a share of cost have incomes that exceed a certain threshold, preventing them from qualifying for full Medi-Cal benefits. The share of cost amount is used to offset the member’s “excess income” (reducing the income below the threshold of the qualification for full Medi-Cal benefits).

Once the member has met the share of cost amount, providers may not charge the member additional payments.

Please note that Medi-Cal share of cost requirements apply to a OneCare (HMO SNP) member’s ability to access Medi-Cal covered benefits, and have no bearing on the member’s ability to access their Medicare covered benefits. **OneCare (HMO SNP) members are not required to meet their share of cost to access Medicare benefits.** For a list of OneCare (HMO SNP)’s Medicare and Medi-Cal covered benefits, please see **Section C1: Covered Services.**

**HOW TO DETERMINE AND CLEAR A MEMBER’S SHARE OF COST**

Providers need to report member payment (or obligation through a payment plan) to the Medi-Cal Eligibility Verification System in order to clear a member’s share of cost.

Payment or obligation for all medically necessary health services, whether Medi-Cal covered or not, can be used to meet the member’s share of cost requirement.

There are three ways to determine whether a member has a Medi-Cal share of cost and to clear the share of cost:

1. By logging on to Medi-Cal website: [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov/)
2. By calling the Automated Eligibility Verification System (AVES) at **800-456-2387**
3. By using a Point of Service (POS) device
E5: SHARE OF COST FOR LONG-TERM CARE (LTC) SERVICES

Some CalOptima beneficiaries qualify for their Medi-Cal benefit with a monthly share of cost. Members in this category must meet a specified share of cost for their medical care expenses before they can be certified to receive Medi-Cal or CalOptima benefits. This monthly share of cost is based on the member’s monthly income. The process for rendering services and receiving reimbursement for these members remains unchanged under CalOptima. These members must pay for services rendered until their monthly share of cost is met. Once the share of cost is met, the LTC facility notifies the State of California Department of Health Care Services (DHCS) by clearing the member’s share of cost, and the member will become eligible for CalOptima for the remainder of the month. Once the member becomes eligible for CalOptima for the month, all CalOptima Direct prior authorization guidelines apply.

CalOptima Direct is not responsible for the reimbursement of services until the member meets his or her share of cost for the month.

LTC facilities must perform an eligibility verification transaction every month for each Medi-Cal beneficiary or CalOptima member residing in the facility. The eligibility verification transaction will show how much share of cost a beneficiary must pay for the month, if any. If the beneficiary has not met any of the share of cost with a provider for the month, the facility will bill the patient for the entire share of cost. If the patient has spent any money on “non-covered” medical or remedial services or items, the facility subtracts those amounts for non-covered services/items from the patient’s share of cost and bills the patient in an amount equal to the patient’s share of cost minus the non-covered items.

Example: Share of Cost ($550) – NCS ($100) = Bill Patient’s Share of Cost ($450)

Medical expenses incurred during the month by new patients while outside the facility may also reduce the amount which the facility bills the patient.

Note: LTC facilities must document a patient’s expenditures on non-covered medical services and items by completing the form DHS 6114, which can be ordered from Electronic Data System or accessed on the Medi-Cal website.

To determine how much to bill CalOptima, subtract from the facility’s monthly Medi-Cal rate the amount billed to the patient, and bill CalOptima for the remainder in accordance with CalOptima claims procedures outlined in this manual.

Example: LTC Facility Daily Rate ($2,500) – Share of Cost ($450) = Bill CalOptima ($2,050)

Providers should notify DHCS when payment is received from a Medi-Cal beneficiary as part of the member’s share of cost. For further information regarding share of cost, refer to the DHCS LTC Medi-Cal Manual.

CalOptima operates in accordance with established Medi-Cal guidelines.
F1: OBTAINING AUTHORIZATION FOR MEDICAL SERVICES

The purpose of a referral authorization is to track referrals to specialists or other providers and furnish instructions to the referring provider for proper billing of services. There are several basic concepts underlying OneCare (HMO SNP)’s referral authorization process:

- **Authorization of Medicare Services: OneCare (HMO SNP) Health Network Responsibility** — In general, all Medicare covered services requiring authorization are reviewed by the member’s OneCare (HMO SNP) health network. OneCare (HMO SNP) health networks authorize specialty consultations, medical treatments, hospital admissions, skilled nursing admissions, hospice admissions and certain ancillary services. Please contact the member’s OneCare (HMO SNP) health network for more information on which benefits require an authorization request and the entity to which the request should be directed.

Please note that some services qualify for self-referral or direct referrals. For more information about self-referrals and direct referrals, see **Section F3: Self Referrals and Direct Referrals**.

- **Services Covered by Medi-Cal: OneCare (HMO SNP) Responsibility** — OneCare (HMO SNP) members may use Medi-Cal when they exhaust Medicare coverage of a specific service or may require services only covered by Medi-Cal. OneCare (HMO SNP), and not its health networks, is responsible for authorizing referrals for Medi-Cal covered services. For more information on Medi-Cal covered benefits for OneCare (HMO SNP) members, please visit the Members section of the CalOptima website.

- **Referral Authorization Determination Time Frames** — Basic authorization processing turnaround times for OneCare (HMO SNP) reflect Medicare’s required time frames. Turnaround time frames start from the date or time that OneCare (HMO SNP) or its health network receives the authorization request. The turnaround times are as follows:
  - Routine authorizations — 14 days
  - Expedited authorizations — 72 hours
  - Retroactive authorizations — 30 days

- **Time Frame Extensions** — OneCare (HMO SNP) or its contracted health network can extend the time frame for making a determination by up to 14 days, if the OneCare (HMO SNP) medical director or the health network’s medical director determines that such a delay would be in the best interests of the member.

- ** Expedited Authorizations** — A member, member’s authorized representative or physician may request an expedited review of an authorization request if he or she believes that OneCare (HMO SNP)’s standard time frame may seriously jeopardize the life or health of the member and his or her ability to regain maximum function.

**TIPS ON WHEN/HOW TO REQUEST A REFERRAL**

1. When a member requests specific services, treatment or referral to a specific physician, the provider should review the request for medical necessity.
2. If there is no medical indication for the requested treatment, service or provider, the provider should discuss an alternative treatment plan with the member.

3. If the member is not satisfied with the alternative treatment plan, the provider should submit the member’s request. Please note that the PCP may indicate on the referral request form that he or she is submitting the request on behalf of the member but that he or she does not concur that the requested service is medically necessary.

4. The provider should check the member’s eligibility to verify the member’s OneCare (HMO SNP) health network. The provider should select a referral provider from the member’s OneCare (HMO SNP) health network to ensure that the referral is directed to an appropriate in-network provider.

5. **If the service needs to be authorized by a OneCare (HMO SNP) health network**, the provider should complete the OneCare (HMO SNP) health network’s authorization request form and submit the form to the health network. For OneCare (HMO SNP) health network contact information, see Section B1: CalOptima Department and Program Contact Information.

6. **If the service needs to be authorized by OneCare (HMO SNP)** — The provider should complete the Authorization Request Form. To obtain a copy, please visit the Providers section of the CalOptima website.

   Please fax the request to OneCare (HMO SNP)’s Utilization Management department:
   
   a. For urgent requests (72-hour process), fax to 714-338-3137
   b. For routine requests, fax to 714-246-8579
   c. For retroactive authorizations, fax to 714-246-8579

7. Please note that referrals to non-contracted and or out-of-network providers must be approved by the appropriate utilization management entity (i.e., the OneCare (HMO SNP) health network or OneCare (HMO SNP), as appropriate).

8. The OneCare (HMO SNP) health network or OneCare (HMO SNP) will notify the requesting provider and the member of its authorization determination (in accordance with the turnaround time frames noted above).

9. Once the OneCare (HMO SNP) health network or OneCare (HMO SNP) renders a decision, the medical group will notify and provide the referral authorization form to the referring provider and member.

A member, member’s representative or provider may appeal an adverse organizational determination. For more information on how a provider can file an appeal on behalf of the member, please see Section R6: Filing on Behalf of a Member.

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**CalOptima Policies and Procedures:**

MA.6003: Authorization Process
**F1: OBTAINING AUTHORIZATION FOR MEDICAL SERVICES**

The purpose of a referral authorization is to maximize the member’s covered services by validating eligibility and ensuring that the member receives services in a timely manner, by the most qualified provider in the appropriate setting and furnishing instructions to the referring provider for proper billing of services. There are several basic concepts underlying OneCare Connect’s referral authorization process:

- **Authorization of Medicare Services: OneCare Connect Health Network Responsibility** — In general, all Medicare covered services requiring authorization are reviewed by the member’s OneCare Connect health network. OneCare Connect health networks authorize specialty consultations, follow-up specialty visits, medical treatments, hospital admissions, skilled nursing admissions, hospice admissions and certain ancillary services. Please contact the member’s OneCare Connect health network for more information on which benefits require an authorization request and the entity to which the request should be directed.

Please note that some services qualify for self-referral or direct referrals. For more information about self-referrals and direct referrals, see **Section F3: Self Referrals and Direct Referrals**.

- **Services Covered by Medi-Cal: OneCare Connect Responsibility** — OneCare Connect members may use Medi-Cal when they exhaust Medicare coverage of a specific service or may require services only covered by Medi-Cal. For more information on Medi-Cal covered benefits for OneCare Connect members, please visit the Members section of the CalOptima website.

- **Referral Authorization Determination Time Frames** — Basic authorization processing turnaround times for OneCare Connect reflect Medicare’s required time frames. Turnaround time frames start from the date or time that OneCare Connect or its health network receives the authorization request. The turnaround times are as follows:
  - Routine authorizations — 14 days
  - Expedited authorizations — 72 hours
  - Retroactive authorizations — 30 days

- **Time Frame Extensions** — OneCare Connect or its contracted health network can extend the time frame for making a determination by up to 14 days, if the OneCare Connect medical director or the health network’s medical director determines that such a delay would be in the best interests of the member.

- **Expedited Authorizations** — A member, member’s authorized representative or physician may request an expedited review of an authorization request if he or she believes that OneCare Connect’s standard time frame may seriously jeopardize the life or health of the member and his or her ability to regain maximum function.

**TIPS ON WHEN/HOW TO REQUEST A REFERRAL**

1. When a member requests specific services, treatment or referral to a specific physician, the provider should review the request for medical necessity.
2. If there is no medical indication for the requested treatment, service or provider, the provider should discuss an alternative treatment plan with the member.

3. If the member is not satisfied with the alternative treatment plan, the provider should submit the member’s request. Please note that the primary care provider (PCP) may indicate on the referral request form that he or she is submitting the request on behalf of the member but that he or she does not concur that the requested service is medically necessary.

4. The provider should check the member’s eligibility to verify the member’s OneCare Connect health network. The provider should select a referral provider from the member’s OneCare Connect health network to ensure that the referral is directed to an appropriate in-network provider.

5. **If the service needs to be authorized by a OneCare Connect health network**, the provider should complete the OneCare Connect health network’s authorization request form and submit the form to the health network. For OneCare Connect health network contact information, see **Section B1: CalOptima Department and Program Contact Information**.

   **If the service needs to be authorized by OneCare Connect** — The provider should complete the Authorization Request Form. To obtain a copy, please visit the Providers section of the CalOptima website.

   Please fax the request to OneCare Connect’s Utilization Management department:

   a. For urgent requests (72-hour process), fax to **714-338-3137**
   b. For routine requests, fax to **714-246-8579**
   c. For retroactive authorizations, fax to **714-246-8579**

6. Please note that referrals to non-contracted and or out-of-network providers must be approved by the appropriate utilization management entity (i.e., the OneCare Connect health network or OneCare Connect, as appropriate).

7. The OneCare Connect health network or OneCare Connect will notify the requesting provider and the member of its authorization determination (in accordance with the turnaround time frames noted above).

8. Once the OneCare Connect health network or OneCare Connect renders a decision, the medical group will notify and provide the referral authorization form to the referring provider and member.

9. If OneCare Connect or the OneCare Connect health network delays the authorization determination, it will immediately notify the requesting provider and member in writing. The notice will include the reason for the delay, a request for additional information, if appropriate, and the date by which the provider and member may anticipate a determination.

A member, member’s representative or provider may appeal an adverse organizational determination. For more information on how a provider can file an appeal on behalf of the member, please see **Section R6: Filing on Behalf of a Member**.

**CalOptima Policies and Procedures:**

MA.6003: Authorization Process
This section applies to the following CalOptima programs:

Medi-Cal

F1: OBTAINING AUTHORIZATION FOR MEDICAL SERVICES

CalOptima and its health networks perform utilization management functions, including referral authorization, to promote the provision of medically appropriate care and to monitor, evaluate and manage the cost-effectiveness and quality of health care delivered to our members.

Both CalOptima and its health networks conduct prospective review to evaluate referrals for specified services or procedures that require authorization. Authorization determinations made by licensed review nurses are based on medical necessity and appropriateness and reflect the application of approved review criteria and guidelines. Physician review and determination is required for all final denial decisions for requested medical services. The review of the denial of a pharmacy prior authorization may be by a qualified physician or pharmacist. Medicare/Medi-Cal members are an exception to the pre-authorization requirement, as Medicare is the primary payer in these instances.

If a provider requests services for members enrolled in a CalOptima health network, the provider will submit the request for authorization to the member’s health network. For members enrolled in CalOptima Direct, the provider will submit the request for authorization to the CalOptima Utilization Management department by mail, fax and or telephone, depending on the urgency of the requested service.

HOW TO REQUEST AUTHORIZATION FOR SERVICES

1. The provider should first verify the member’s eligibility with CalOptima. For potential retroactive eligibility, the provider should check the Medi-Cal eligibility system systems monthly. For more information on verifying a member’s eligibility, see Section E1: Verifying Member Eligibility.

2. For health network members — If the member is enrolled in a CalOptima health network, the provider should contact the member’s health network for information on how to request an authorization from that health network and follow the specific instructions from the member’s health network for requesting authorization. For CalOptima health network contact information, see Section: B1: CalOptima Department and Program Contact Information.

   If the member is enrolled in CalOptima Direct or CalOptima Community Network (CCN), see steps 3–5 below.

3. For CalOptima Direct and CalOptima Community Network (CCN) members, complete the Authorization Request Form (ARF) and submit it to CalOptima’s Utilization Management department. A copy of the ARF is on CalOptima’s website at: www.caloptima.org/. Routine authorizations may also be requested through CalOptima Link located in the Providers section of CalOptima’s website.

   a. In completing the form, please be sure to supply the following information for the requested service: Member’s demographic information (name, date of birth, etc.)
   b. Provider’s demographic information (referring and referred to)
   c. Requested service/procedure, including specific CPT/HCPCS codes
   d. Member diagnosis (ICD-10 code and description)
   e. Clinical indications necessitating service or referral
   f. Pertinent medical history and treatment
   g. Location where service will be performed
4. Once the provider has completed the form, the provider should submit the form to the CalOptima Utilization Management department using:
   a. For Urgent requests, fax to 714-338-3137. The 72-hour process, must meet urgent criteria in accordance with CA Health and Safety Code sections 1367.01(h)(2).
   b. For Routine requests, fax to 714-246-8579.
   c. For Retroactive Authorizations, fax to 714-246-8579.

**TIME FRAMES FOR MEDICAL AUTHORIZATION**

1. **Emergency Care:** No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2. **Post-stabilization:** Upon receipt of an authorization request from an emergency services provider, CalOptima or the health network shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4.

3. **Non-urgent care following an exam in the emergency room:** Response to request within 30 minutes or deemed approved.

4. **Concurrent review of authorization for treatment regimen already in place:** Within 24 hours of the decision, consistent with urgency of the member’s medical condition and in accordance with Health and Safety Code Section 1367.01(h)(3).

5. **Retrospective review:** Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1).

6. **Pharmaceuticals:** 24 hours or one business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

7. **Therapeutic Enteral Formula for Medical Conditions in Infants and Children:** Time frames for medical authorization of medically necessary therapeutic enteral formulas for infants and children and the equipment/supplies necessary for delivery of these special foods are set forth in MMCD Policy Letter 07-016, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.

8. **Routine authorizations:** Five working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but no longer than 14 calendar days from the receipt of the request. The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or the member’s provider requests an extension, or CalOptima or the member’s health network can provide justification upon request by stating the need for additional information and how it is in the member’s best interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

9. **Expedited authorizations:** For requests in which a provider indicates, or CalOptima or the member’s health network determines that, following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function, CalOptima or the member’s health network must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later than 72 hours after receipt of the request for services. CalOptima or the member’s health network may extend the three working days’ time period by up to 14 calendar days if the member requests an extension or if CalOptima or the member’s health network justifies to the Department of Health Care Services (DHCS) upon request, a need for additional information and how the extension is in the member’s interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
CalOptima Policies and Procedures:

GG.1500: Authorization Instructions for CalOptima Direct Providers

GG.1508: Authorization and Processing of Referrals
This section applies to the following CalOptima programs:

Medi-Cal

**F2: SERVICES NOT REQUIRING AUTHORIZATION**

Certain Medi-Cal covered services do not require prior authorization, irrespective of whether the member seeking the service is enrolled in a health network or in CalOptima Direct.

Please note that the following services do not require prior authorization:

- Emergency services
- Family planning services for network or out-of-plan providers
- Sensitive services (which include family planning)
- Sexually transmitted disease services
- Abortion
- Human immunodeficiency virus (HIV) testing
- Basic prenatal care services
- Routine obstetric services
- Pediatric preventive services
- Minor consent services
- Primary and preventive care services

**HOW TO OBTAIN MORE INFORMATION**

To obtain more information about services not requiring prior authorization, please call the CalOptima Provider Resource Line at **714-246-8600**.

**CalOptima Policies and Procedures:**

- GG.1508: Authorization and Processing of Referrals
- GG.1500: Authorization Guidelines for CalOptima Direct Providers
F3: SELF-REFERRALS AND DIRECT REFERRALS

OneCare Connect members may self-refer for certain covered services within their OneCare Connect health network. Physicians may also directly refer OneCare Connect members to a contracted provider for selected covered services referenced in this section of this manual under Direct Referral.

HOW TO SELF-REFER AND REQUEST A DIRECT REFERRAL

Self-Referral — A member may self-refer within their health network for the following annual covered services without a referral from their primary care provider (PCP) or authorization from OneCare Connect or the health network:

- **Women’s Preventive Health** — Women’s preventive health includes well-woman visits, clinical breast exams, mammograms and cervical cancer screenings. A woman’s health specialist is defined as:
  - Gynecologist
  - Certified nurse midwife
  - Other qualified health care provider

- **Certain Immunizations** — A member may self-refer to an in-network physician for an annual flu vaccine, pneumococcal and tetanus vaccinations. OneCare Connect members may not be charged for these vaccines.

OneCare Connect or a health network may require pre-service authorization for initial and subsequent visits, treatments or surgeries.

- **Direct Referral** — A physician may directly refer a OneCare Connect member for specific covered services by referring the member directly to the contracted provider. OneCare Connect or its contracted health networks do not require authorization for payment of a claim for covered services designated as a direct referral service.

The following services are available for direct referral by a provider or the member:

- **Mental Health Services** — For more information on how to refer a member for mental health services, see Section C10: Mental Health Services.
- **Dental Services** — For more information on how to refer a member for dental services, see Section D5: Dental Benefit for OneCare Connect Members.
- **Transportation Taxi Services** — For more information on how to refer a member for taxi services, please see Section F10: Transportation Taxi Benefit for OneCare Connect Members.
F3: SELF-REFERRALS AND DIRECT REFERRALS

OneCare (HMO SNP) members may self-refer for certain covered services within their OneCare (HMO SNP) health network. Physicians may also directly refer OneCare (HMO SNP) members to a contracted provider for selected covered services referenced in this section of this manual under Direct Authorization Referral.

HOW TO SELF-REFER AND REQUEST A DIRECT REFERRAL

Self-Referral — A member may self-refer within their health network for the following annual covered services without a referral from their primary care provider (PCP) or authorization from OneCare (HMO SNP) or the health network:

- **Women’s Preventive Health** — Women’s preventive health includes well-woman visits, clinical breast exams, mammograms and cervical cancer screenings. A woman’s health specialist is defined as:
  - Gynecologist
  - Certified nurse midwife
  - Other qualified health care provider

- **Certain Immunizations** — A member may self-refer to an in-network physician for an annual flu vaccine, pneumococcal and tetanus vaccinations. OneCare (HMO SNP) members may not be charged for these vaccines.

OneCare (HMO SNP) or a health network may require pre-service authorization for initial and subsequent procedures, treatments or surgeries.

- **Direct Authorization Referral** — A physician may directly refer a OneCare (HMO SNP) member for specific covered services by submitting an authorization request directly to the contracted provider. OneCare (HMO SNP) or its contracted health networks do not require authorization for payment of a claim for covered services designated as a direct referral service.

The following services are available for direct referral by a provider or the member:

- **Mental Health Services** — For more information on how to refer a member for mental health services, see Section C10: Mental Health Services.
- **Dental Services** — For more information on how to refer a member for dental services, see Section D5: Dental Benefit for OneCare Members.
- **Transportation Taxi Services** — For more information on how to refer a member for taxi services, please see Section F10: Transportation Taxi Benefit for OneCare Members.

CalOptima Policies and Procedures:

MA.6003: Authorization Process
F4: SECOND OPINIONS

A CalOptima Medi-Cal member or the member’s authorized representative may request a second medical opinion through their provider or by contacting CalOptima or their health network. CalOptima or the health network must review the request for medical necessity.

CalOptima will authorize a request for a second opinion based on, but not limited to, the following criteria:
- A member questions the reasonableness or necessity of a recommended surgical procedure.
- A member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including, but not limited to, a serious chronic condition.
- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition, and the member requests an additional diagnosis.
- The treatment plan in progress is not improving the member’s medical condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- A member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

IMPORTANT TIPS ON REQUESTING SECOND OPINIONS

1. To request a second opinion on behalf of a member, please contact the member’s health network. For Medi-Cal health network contact information, see Section B1: CalOptima Department and Program Contact Information.
2. Referrals for second opinions should be directed to a provider who is contracted with the member’s health network. Referrals to non-contracting medical providers or facilities will be approved only when the requested services are not available within the contracting network.
3. Second medical opinions can only be rendered by a physician qualified to review and treat the medical condition in question.
4. If the provider giving the second medical opinion recommends a particular treatment, diagnostic tests or service that is covered by Medi-Cal, and if it is medically necessary, the member’s health network will provide or arrange for services.
5. If CalOptima or the health network denies a request by the member for a second opinion, CalOptima or delegated health network will notify the member in writing of the following:
   a. Reasons for the denial
   b. Member’s right to appeal the denial by filing a standard service appeal or expedited appeal
   c. Information about how to contact and file a complaint with the Department of Managed Health Care
6. CalOptima or the delegated physician medical group will authorize a request for a third opinion if the recommendations of the first and second practitioner differ regarding the need for a medical procedure and a member, authorized representative or physician requests such third opinion.
F4: SECOND OPINIONS

OneCare (HMO SNP) members may request a second medical opinion regarding a recommended procedure or service through their primary care provider (PCP). The health network (or OneCare (HMO SNP) medical director) must review the request for medical necessity. All decisions regarding second opinions must be rendered within the following time limits:

- **Urgent initial determinations** — within 72 hours
- **Standard pre-service** — within 14 calendar days

OneCare (HMO SNP) will authorize a request for a second opinion based on, but not limited to, the following criteria:

- A member questions the reasonableness or necessity of a recommended surgical procedure.
- A member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including, but not limited to, a serious chronic condition.
- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition, and the member requests an additional diagnosis.
- The treatment plan in progress is not improving the member’s medical condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- A member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

IMPORTANT TIPS ON REQUESTING SECOND OPINIONS

1. To request a second opinion on behalf of a member, please contact the member’s OneCare (HMO SNP) health network. For OneCare (HMO SNP) health network contact information, see Section B1: CalOptima Department and Program Contact Information.
2. Referrals for second opinions should be directed to a provider who is contracted with the member’s health network. Referrals to non-contracting medical providers or facilities will be approved only when the requested services are not available within the contracting network.
3. Second medical opinions can only be rendered by a physician qualified to review and treat the medical condition in question.
4. If the provider giving the second medical opinion recommends a particular treatment, diagnostic tests or service that is covered by OneCare (HMO SNP), and if it is medically necessary, the member’s OneCare (HMO SNP) health network will provide or arrange for services.
5. If OneCare (HMO SNP) or the health network denies a request by the member for a second opinion, OneCare (HMO SNP) or delegated health network will notify the member in writing of the following:
   a. Reasons for the denial
   b. Member’s right to appeal the denial according to CalOptima OneCare (HMO SNP) policies MA.9003: Standard Service Appeal and MA.9004: Expedited Service Appeal
   c. Information about how to contact and file a complaint with the Department of Managed Health Care
6. OneCare (HMO SNP) or the delegated health network will authorize a request for a third opinion if the recommendations of the first and second practitioner differ regarding the need for a medical procedure and a member, authorized representative or physician requests such third opinion.

CalOptima Policies and Procedures:
- MA.6005: Referrals for Second Opinion
- MA.9003: Standard Service Appeal
- MA.9004: Expedited Service Appeal
F4: Second Opinions

This section applies to the following CalOptima programs:

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

F4: SECOND AND THIRD OPINIONS

OneCare Connect members may request a second medical opinion regarding a recommended procedure or service through their primary care provider (PCP). A third opinion can be requested if there is a disparity between the initial and second opinion. The health network (or OneCare Connect medical director) must review the request for medical necessity. All decisions regarding second opinions must be rendered within the following time limits:

- **Urgent initial determinations** — within 72 hours
- **Standard pre-service** — within 14 calendar days

OneCare Connect will authorize a request for a second opinion based on, but not limited to, the following criteria:

- A member questions the reasonableness or necessity of a recommended surgical procedure.
- A member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including, but not limited to, a serious chronic condition.
- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition, and the member requests an additional diagnosis.
- The treatment plan in progress is not improving the member’s medical condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- A member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

IMPORTANT TIPS ON REQUESTING SECOND OPINIONS

1. To request a second opinion on behalf of a member, please contact the member’s OneCare Connect health network. For OneCare Connect health network contact information, see Section B1: CalOptima Department and Program Contact Information.
2. Referrals for second opinions should be directed to a provider who is contracted with the member’s health network. Referrals to non-contracting medical providers or facilities will be approved only when the requested services are not available within the contracting network.
3. Second medical opinions can only be rendered by a physician qualified to review and treat the medical condition in question.
4. If the provider giving the second medical opinion recommends a particular treatment, diagnostic tests or service that is covered by OneCare Connect, and if it is medically necessary, the member’s OneCare Connect health network will provide or arrange for services.
5. If OneCare Connect or the health network denies a request by the member for a second opinion, OneCare Connect or delegated health network will notify the member in writing of the following:
   a. Reasons for the denial
   b. Member’s right to appeal the denial according to CalOptima OneCare Connect policies and procedures
   c. Information about how to contact and file a complaint with the Department of Managed Health Care
6. OneCare Connect or the delegated health network will authorize a request for a third opinion if the recommendations of the first and second practitioner differ regarding the need for a medical procedure and a member, authorized representative or physician requests such third opinion.
F5: TIPS TO EXPEDITE AUTHORIZATION REQUESTS

If a provider plans to request authorization for services for a CalOptima Direct or CalOptima Community Network (CCN) member, following several simple tips will help the provider expedite the authorization request. Please keep the following tips in mind when completing the Authorization Request Form (ARF).

HOW TO EXPEDITE CALOPTIMA DIRECT AUTHORIZATION REQUESTS

1. **Check Eligibility First** — Providers should always verify the member’s eligibility first. Please note that if CalOptima is not stated in the eligibility verification, the beneficiary is probably not a CalOptima member (CalOptima is for Orange County beneficiaries only, and does not cover members in all Medi-Cal aid codes). To obtain a copy of the aid code listing that references the aid codes included in CalOptima and the aid codes that are straight Medi-Cal members, please visit the Medi-Cal website at: www.medi-cal.ca.gov.

2. **Check for the Member’s Health Network** — Providers should check to see if the member is enrolled in a CalOptima health network or in CalOptima Direct.
   
   a. If the member is enrolled in a health network, the authorization must come from the health network.
   
   b. If Medicare is primary and the member is not in a Medicare HMO, the provider should bill Medicare. No authorization is required for Medicare services to members in Medicare.
   
   c. CalOptima Direct covers certain CalOptima members, including members who are dually eligible for Medicare and Medi-Cal, Foster Care, Long-Term Care, Breast and Cervical Cancer Treatment Program members, end-stage renal disease, transplant, hemophiliacs, seniors and persons with disabilities (SPD), members transitioning into a health network and share of cost members.
   
   d. Beneficiaries (members) new to CalOptima and eligible for health network enrollment choose a health network or have one auto-assigned to them. If the member under a provider’s care desires to stay with that provider, the provider should advise the member of his or her health network affiliation.

3. **Include Critical Information** — Providers should include the following critical information when completing the Authorization Request Form (ARF):
   
   a. **Member Identification Number** — Due to the large volume of members in the CalOptima system, the member’s client index number (CIN) is required in order to accurately identify the member.
   
   b. **Member’s Date of Birth** — The member’s date of birth is required in order to verify eligibility on the state’s eligibility verification systems.
   
   c. **Referring Provider** — This is necessary in case more information is required to process the request.
   
   d. **Provider Rendering Service** — CalOptima does not assign providers. The requested provider’s name, address and contact number are all necessary to complete an authorization.
   
   e. **Provider Contact Information** — When a provider’s phone or fax information is not available, CalOptima will mail Notices of Action and or requests for additional information on provider requests to the provider.
   
   f. **Requested Procedures and Codes** — Only the code numbers listed on the authorization will be paid on a claim. To obtain a copy of the Authorization Required Code List, please visit the Providers section of the CalOptima website. If no code exists for the requested service and a generic code is
used, documentation must accompany the ARF. To obtain a copy of the form, please visit the Providers section of the CalOptima website.

g. **Diagnosis Codes** — ICD-10 diagnosis codes are required. Many of the ICD-10 diagnosis codes are linked to procedure codes, member’s age and gender. This mapping is programmed into CalOptima’s system, and if the code is missing or incorrect, the system will automatically deny the authorization.

h. **Documentation** — To support the requested services, it is required to substantiate the medical necessity. A diagnosis or test name is not adequate. In order to expedite and ensure your authorization request is processed, please ensure that the member’s name is on each page of the information faxed to CalOptima.

i. **Dates of Service and Number of Units** — This information must match the same information provided on the claim submitted.

4. **Do Not Send Duplicates** — All ARFs are logged in and distributed to the Prior Authorization department. Duplicate requests increase the volume of ARFs received and slow down the process.

5. **Checking on Fax Requests** — To follow up on a routine fax request for prior authorization, be sure that you have allowed at least 72 hours processing time before calling.

6. **Emergency Department (ED) Services** — ED services for CalOptima Direct members DO NOT require prior authorization.

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**CalOptima Policies and Procedures:**

GG.1500: Authorization Instructions for CalOptima Direct Providers
F6: CALOPTIMA DIRECT SERVICES REQUIRING AUTHORIZATION

CalOptima Direct requires that providers request prior authorization for certain selected health care services. The list below identifies the services that currently require prior authorization, including, but not limited to:

- Inpatient services
- Selected outpatient surgeries (except where otherwise specified, i.e., minor office procedures)
- Selected major diagnostic tests
- Hearing aids
- Disposable incontinence supplies
- Home health care
- Elective services at tertiary level of care centers
- Hospice care
- Non-emergency medical transportation
- Prosthetics
- Outpatient physical therapy, occupational therapy, speech therapy
- Selected durable medical equipment
- Unlisted, miscellaneous or “by report” codes
- New medical technology (considered investigational or experimental — includes drugs, treatment, procedures, equipment, etc.)
- Medications not on the CalOptima Approved Drug List and or exceeding the CalOptima monthly medication limit. For more information on monthly medication limits, see Section I3: Monthly Medication Limit.
- All admissions to long-term care (LTC) facilities require prior authorization. For more information on admissions to long-term care facilities, see Section C4: Long-Term Care Service Referrals.

On October 1, 2015, CalOptima implemented new authorization requirements for professional services for CalOptima Community Network (CCN).

MEMBERS WITH ASSIGNED PRIMARY CARE PROVIDERS (PCPs)

For primary care provider (PCP) services, the following authorization requirements apply:

- No authorization is required for visits to the assigned PCP or affiliated group physician.
- Visits to non-assigned PCPs will be considered out-of-network and require authorization even if the provider is acting in the capacity of a PCP.

For specialty services, the following authorization requirements apply:

- All visits must be authorized by either the assigned PCP or contracted specialist, including post-hospital discharge visits.
- All initial requests must originate from the PCP post-hospital visit. The initial prior authorization will include one specialty consult plus one follow-up visit; additional follow-up visits require a new prior authorization. If a specialist is acting as a PCP (OB/GYN, internal medicine, pediatrics, family practice, general practice) and refers to a specialty, all visits must be authorized.
- The specialist may request additional visits once the initial visit request is approved.
MEMBERS WITHOUT ASSIGNED PRIMARY CARE PROVIDERS (PCPs)

For primary care provider (PCP) services, the following authorization requirements apply:

- No authorization is required for a contracted PCP.
- For non-contracted PCPs, the initial visit does not require authorization. Additional visits must be authorized.

For specialty services, the following authorization requirements apply:

- Initial visit does not require authorization; however, additional visits must be authorized.
- Members may self-refer or be referred by other providers to specialists for one visit only.
- Specialist requests require additional authorization after the initial visit.

CalOptima routinely analyzes utilization patterns to determine whether it would be in the interest of its members to remove or add services from the prior authorization requirement. CalOptima may adjust the list of services requiring prior authorization by amending CalOptima policy GG.1500: Authorization Instructions for CalOptima Direct Providers and GG.1508: Authorization and Processing of Referrals, as appropriate.

URGENT REFERRALS

Urgent referrals are only to be submitted if the normal time frame for authorization will either:

- Be detrimental to the patient’s life or health
- Jeopardize patient’s ability to regain maximum function
- Result in loss of life, limb or other major bodily function

All referrals not meeting urgent criteria will be downgraded to a routine referral request and follow routine turn-around times.

LIST OF PROCEDURE CODES REQUIRING AUTHORIZATION

CalOptima posts detailed listings of procedure codes requiring prior authorization for services provided to CalOptima Direct members on its website. To access the Authorization Required Code Lists, please visit the Providers section of the CalOptima website.

To obtain more information about services not requiring prior authorization, please call the CalOptima Provider Resource Line at 714-246-8600.

**CalOptima Policies and Procedures:**

GG.1500: Authorization Instructions for CalOptima Direct Providers

GG.1508: Authorization and Processing of Referrals

GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)

GG.1802: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from ICF/DD, ICF/DD-H, and ICF/DD-N

GG.1803: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric

GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-State Skilled Nursing Facility (SNF)
F7: CALOPTIMA DIRECT RETROACTIVE AUTHORIZATION REQUESTS

CalOptima Direct will consider retroactive authorization (retro-authorization) requests for services that normally require prior authorization, but only under the following conditions:

- When “other coverage” (e.g., Medicare Part A, California Children’s Services or other health insurance coverage) denied payment of a claim for services. Submission of the request to CalOptima Direct must be received within 60 days of the “other coverage” denial determination and must include the dated letter of denial and documentation of outcome of all levels of appeal.
- When communication with CalOptima could not be established and provision of the required service should not have been delayed.
- When a patient does not identify himself or herself to the provider as a Medi-Cal beneficiary by deliberate concealment or because of the patient’s inability to identify himself or herself due to a physical or mental impairment (and the patient was CalOptima eligible at time of service).

GUIDELINES FOR RETRO-AUTHORIZATION

1. Check eligibility at the time of service and twice a month thereafter for cash accounts and Medi-Cal pending accounts. (CalOptima auto-assigns and enrolls members to health network choices on the 1st and 16th of the month.)

2. CalOptima will consider retro-authorization requests that meet one of the following conditions:
   a. Late authorization requests for services to CalOptima Direct members who are eligible on the date(s) of service may be considered if the request is received by CalOptima’s Utilization Management department within 60 days of the initial date of service (For inpatient acute services, date of service means date of admission.)
   b. Late authorization requests for services to CalOptima Direct members who have lost eligibility and regained it may be considered if the request is received by CalOptima within 60 days of the state’s eligibility determinations.
   c. A natural disaster which has:
      i. Destroyed or damaged the provider’s business office or records
      ii. Substantially interfered with a provider’s agent’s processing of the provider’s retro-authorization request
   d. Delay caused by other circumstances beyond the control of the provider, which has been reported to the appropriate law enforcement or fire agency when applicable.

Initial retro-authorization requests and requests submitted on appeal must include factual documentation to verify that the late submission was due to one of the above-mentioned conditions.

3. Circumstances which shall not be considered beyond the control of the provider include, but are not limited to:
   a. Negligence by employees
   b. Misunderstanding of program requirements
   c. Illness or absence of any employee trained to prepare retro-authorization requests
   d. Delays caused by the United States Postal Services or any private delivery service
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F8: WHEELCHAIR AUTHORIZATION AND REPAIR REQUESTS

Medi-Cal covers a wheelchair if it is needed to:

- Prevent significant illness or disability.
- Ease severe pain.
- Maintain bodily functions needed to perform daily activities.

Medi-Cal does not cover a wheelchair if a household or furniture item could otherwise serve the member’s needs. Providers are required to obtain prior authorization from CalOptima or one of its health networks for:

- The purchase or rental of standard and custom wheelchairs
- The repair of a standard or custom wheelchair that exceeds $250

HOW TO REQUEST AUTHORIZATION OF A STANDARD WHEELCHAIR

1. If a provider identifies a health network member in need of a standard wheelchair, the provider should contact the member’s health network to obtain an authorization request form. For health network contact information, see Section B1: CalOptima Department and Program Contact Information.

2. If a provider identifies a CalOptima Direct member in need of a standard wheelchair, the provider should complete an Authorization Request Form (ARF). To obtain a copy of this form, please visit the Providers section of the CalOptima website.

3. When completing the form for either the health network or CalOptima Direct, the provider must supply the following information:

   a. Member’s name, date of birth, phone number, address and Medi-Cal Client Identification Number (CIN)
   b. Full name, address, telephone number and signature of the prescribing provider
   c. Date of request
   d. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes

4. If the request involves a health network member, the provider should submit the ARF to the member’s health network. For CalOptima Direct members, the provider should fax the ARF to CalOptima’s Utilization Management department at 714-246-8579.

CalOptima or the health network will approve, modify or deny the request for a standard wheelchair in accordance with CalOptima Policy GG. 1508: Authorization and Processing of Referrals.

HOW TO REQUEST AUTHORIZATION OF A CUSTOM WHEELCHAIR

1. If a provider identifies a health network member in need of a custom wheelchair, the provider should contact the member’s health network to obtain the network’s authorization request documentation. For health network contact information, see Section B1: CalOptima Department and Program Contact Information.
2. If a provider identifies a CalOptima Direct member in need of a custom wheelchair, the provider should complete a Customized Wheelchair Evaluation Request (CWER) form and Wheelchair Clinical Questionnaire. To obtain copies of these forms, please visit the Providers section of CalOptima’s website.

3. When completing the CWER and Clinical Questionnaire, the provider must supply the following information:
   a. Member’s name, date of birth, phone number, address and Medi-Cal Client Identification Number (CIN)
   b. Full name, address, telephone number and signature of the prescribing provider
   c. Date of request
   d. Specific item(s) requested
   e. Member’s medical condition or diagnosis necessitating the custom wheelchair, including functional limitations and a description of how the custom wheelchair would improve the member’s medical status or functional ability

4. If the request involves a health network member, the provider should submit the authorization request to the member’s health network. For CalOptima Direct members, the provider should fax the CWER and Clinical Questionnaire to CalOptima’s Care Coordination department at 714-481-6516. CalOptima or the health network will approve, modify or deny the request for a customized wheelchair evaluation in accordance with CalOptima Policy GG. 1508: Authorization and Processing of Referrals.

   If CalOptima or the health network approves the request for a customized wheelchair evaluation, CalOptima or the health network will contact a contracted evaluation service provider to arrange for an assessment of the member.

   The evaluation service provider will assess the member and the medical necessity of a customized wheelchair based upon criteria identified in CalOptima Policy GG. 1531: Criteria and Authorization Process for Wheelchair Rental, Purchase and Repair, and based upon the member’s medical needs and living environment. The evaluation service provider will submit a letter of recommendation based upon its initial assessment of the member to CalOptima or the health network.

   If the evaluation service provider’s letter of recommendation varies from the provider’s original request, it will be reviewed by the health network’s or CalOptima’s medical director for approval, modification or denial.

   If CalOptima or the health network approves a customized wheelchair, CalOptima or the health network will make arrangements with a selected wheelchair provider. The wheelchair provider will arrange for a fitting appointment with the member.

   If CalOptima or the health network approves the custom wheelchair, CalOptima or the health network will send a letter of authorization to the custom wheelchair vendor.

   For more information, see the Custom Wheelchair Request and Approval Process Provider Fact Sheet by calling the CalOptima Prior Authorization department at 714-246-8686.
HOW TO REQUEST AUTHORIZATION OF A WHEELCHAIR REPAIR

1. Wheelchair repair requests with a cumulative cost less than $250 that do not utilize miscellaneous or “by report” codes, and that do not exceed frequency limitations, do not require prior authorization.

2. If a health network member requires a wheelchair repair costing more than $250 that does not utilize miscellaneous or “by report” codes, provider should contact the member’s health network to obtain an authorization request form. For health network contact information, see Section B1: CalOptima Department and Program Contact Information.

3. If a CalOptima Direct member requires a wheelchair repair costing more than $250 that does not utilize miscellaneous or “by report” codes, the provider should complete a Wheelchair Repairs Authorization Request Form. To obtain a copy of this form, please visit the Providers section of the CalOptima website.

4. When completing the form for either the health network or CalOptima, the provider must supply the following information:
   a. Member’s name, date of birth, phone number, address and Medi-Cal Client Identification Number (CIN)
   b. Full name, address, telephone number and signature of the prescribing provider
   c. Date of request
   d. Description of the repair or maintenance required

5. If the case involves a health network member, the provider should submit the authorization form to the member’s health network. For CalOptima Direct members, the provider should fax the Wheelchair Repairs Authorization Request Form to CalOptima’s Care Coordination department at 714-841-6516.

6. CalOptima or the health network will review the request for benefit coverage, frequency limits and medical necessity. CalOptima or the health network will approve, modify or deny the request for wheelchair repair in accordance with CalOptima Policy GG. 1508: Authorization and Processing of Referrals.

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**CalOptima Policies and Procedures:**

GG. 1508: Authorization and Processing of Referrals

GG. 1531: Criteria and Authorization Process for Wheelchair Rental, Purchase and Repair
F9: NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) REQUESTS

Non-emergency medical transportation (NEMT) services are a Medi-Cal covered benefit. If a CalOptima member is not able to ride in a taxi, he or she may also qualify for non-emergency medical transportation services under his or her Medi-Cal benefit. The non-emergency medical transportation benefit is separate and distinct from the OneCare (HMO SNP) taxi transportation benefit.

Who Qualifies for the Medi-Cal Non-Emergency Medical Transportation Benefit? Non-emergency medical transportation is covered only when a member’s medical and physical condition does not allow the member to travel by bus, passenger car, taxicab or another form of public or private conveyance. A patient meets the Medi-Cal rules if he or she:

- Is not able to sit up and must ride lying down.
- Is in a wheelchair and is not able to move in and out of the chair into a seat, or is not able to move the chair without assistance
- Needs to travel with specialized services, equipment or a caregiver

How Does the Non-Emergency Medical Transportation Benefit Work? There are a few other important points to understand about the non-emergency medical transportation benefit:

- A physician, dentist or podiatrist must provide a prescription, and all non-emergency medical transportation services are subject to prior authorization.
- Transportation is not covered if the member is seeking care that is not a Medi-Cal or Medicare covered service.
- If a member is not able to sit in a wheelchair and transportation by a gurney is necessary, then transportation must be provided by ambulance. The prescription must indicate that transportation by gurney is necessary, and the claim billed using applicable ambulance Current Procedural Terminology (CPT)/HPCS codes.
- Air medical transportation is covered when the medical condition of the patient or practical considerations render ground transportation not feasible.

HOW TO REQUEST NON-EMERGENCY TRANSPORTATION SERVICES FOR A MEMBER

1. Verify the member’s eligibility using CalOptima Link, the Interactive Voice Response (IVR) system or Automated Eligibility Verification System (AEVS). For more information on how to verify member eligibility, see Section E1: Verifying Member Eligibility.

2. If the member is enrolled in a CalOptima health network, please contact the member’s health network. For health network contact information, see B1: CalOptima Department and Program Contact Information.

3. For members enrolled in CalOptima Direct, the provider should complete the Non-Emergency Medical Transportation Authorization Request. To obtain a copy of this form, please visit the Providers section of the CalOptima website.
4. Please be sure to include the following on the Non-Emergency Medical Transportation (NEMT) Authorization Request:
   a. The purpose of the trip
   b. The frequency of the necessary medical transportation or inclusive dates of the requested medical transportation
   c. Medical or physical condition that makes normal public or private transportation inadvisable, with accompanying medical records to substantiate medical necessity
   d. Physician signature and date

5. Please be sure that the form is signed by a physician, dentist or podiatrist.

6. Fax the Non-Emergency Medical Transportation Authorization Request form to CalOptima’s Utilization Management department at 714-338-3153 for authorization.

7. For questions, call the CalOptima Utilization Management department at 714-246-8686.

CalOptima Policies and Procedures:
GG.1505: Transportation, Emergency & Non-Emergency
This section applies to the following CalOptima programs:

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

F10: TRANSPORTATION TAXI BENEFIT FOR ONECARE CONNECT MEMBERS

OneCare Connect offers transportation taxi rides to and from medical appointments at no cost to the member. OneCare Connect even pays for taxi drivers’ tips.

Taxi rides are available for all medical services covered by OneCare Connect. The rides will cover visits to a member’s doctor, dentist, hospital, pharmacy or visits for lab/X-ray services. In addition, the taxi ride benefit may be used to access fitness services at specific contracted gym locations. OneCare Connect covers a set number of one-way rides in a calendar year for medical services within 10 miles of Orange County. For more information on the number of one-way trips covered annually, please see the OneCare Connect Summary of Benefits in the Members section of the CalOptima website.

Please note that if a member’s medical condition prevents him or her from riding in a taxi, he or she may also qualify for the Medi-Cal non-emergency medical transportation benefit. The Medi-Cal non-emergency medical transportation benefit is separate and distinct from the OneCare Connect transportation benefit described above. For more information on the Medi-Cal non-emergency medical transportation benefit, please see Section F9: Non-Emergency Medical Transportation (NEMT) Requests.

HOW TO REQUEST A RIDE

1. To help a member request a ride, call the OneCare Connect Transportation Service toll-free at 866-612-1256, Monday through Friday, from 8 a.m. to 5 p.m.

2. If the member is in a wheelchair or needs other assistance, please call the OneCare Connect Customer Service department toll-free, 24 hours a day, seven days a week, at 855-705-8823, or visit our office Monday through Friday from 8 a.m. to 5:30 p.m. TDD/TTY users can call 800-735-2929. You can also visit our website at www.caloptima.org.

3. The member or provider should have the member’s OneCare Connect ID number ready during the call. Please also have the member’s current address, phone number, appointment time and pick-up and drop-off information available.

4. Rides are available seven days a week. Members or providers should call at least one working day in advance of the appointment. Same-day requests may be provided based upon taxi availability.
F11: INCONTINENCE SUPPLY INFORMATION

Medically necessary incontinence supplies are a Medi-Cal covered benefit. Incontinence supply orders that do not exceed $250 are not subject to prior authorization. Incontinence supply orders in excess of $250, and in quantities in excess of the Medi-Cal allowable quantity, require prior authorization.

CalOptima contracts with a closed network of incontinence supply vendors for CalOptima Direct members. Each CalOptima health network may have its own network of incontinence supply vendors.

TIPS TO REQUEST INCONTINENCE SUPPLIES

If a provider intends to order incontinence supplies for a member who is enrolled in a health network, the provider should contact the member’s health network to obtain information about the health network’s contracted vendors. For health network contact information, see Section B1: CalOptima Department and Program Contact Information.

1. If a provider intends to order incontinence supplies for a CalOptima Direct member, the provider should review the Authorization Procedure Codes listing in the Providers section of the CalOptima website.

2. Claims received for incontinence supplies delivered to a CalOptima Direct member by a non-contracted vendor will be denied with the following message: “The provider and/or vendor of service is NOT a CalOptima Direct contracted vendor. For details about contracted vendors, call 714-347-5777.”

3. Incontinence supplies that are a benefit and payable by primary insurance other than CalOptima Direct may be provided by any vendor that accepts that primary insurance.

CalOptima Policies and Procedures:
GG.1114: Authorization for Disposable Incontinence Supplies
This section applies to the following CalOptima programs:

**Medi-Cal/OneCare/OneCare Connect**

## G1: AUTHORIZATION PROCESS FOR LONG-TERM CARE

The CalOptima Long-Term Services and Supports (LTSS) Authorization department is responsible for the authorization and adjudication of all requests for admissions and continued stays in long-term care (LTC) facilities for all CalOptima members regardless of the member’s county of residence.

This includes CalOptima members who are placed or reside in the following types of facilities:

- Nursing Facility Level A (NF-A) and Level B (NF-B)
- Intermediate Care Facility — Developmentally Disabled (ICF/DD)
- Intermediate Care Facility — Developmentally Disabled-Habilitative (ICF/DD-H)
- Intermediate Care Facility — Developmentally Disabled-Nursing (ICF/DD-N)
- Skilled Nursing Facility (SNF) LTC (Room and Board only)
- Subacute Adult Program
- Subacute Pediatric Program

It is important to note that under CalOptima:

- The LTC Authorization Request Form (ARF) replaces the Treatment Authorization Request (TAR) 20-1 form.
- All LTC ARFs for CalOptima members are processed by CalOptima’s LTSS department in the LTC program.
- The Medi-Cal criteria for admission and extension of stay is utilized in processing and evaluating the LTC ARFs for CalOptima members.

### LONG-TERM SERVICES AND SUPPORTS CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Long-Term Services and Supports Contact Information</th>
<th>Phone Numbers and Website Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CalOptima Long-Term Services and Supports (LTSS) Department Information</strong></td>
<td><strong>General:</strong> 714-246-8444 or 800-965-8979</td>
</tr>
<tr>
<td></td>
<td><strong>Fax Number:</strong> 714-246-8843</td>
</tr>
<tr>
<td></td>
<td><strong>Website:</strong> <a href="http://www.caloptima.org/">www.caloptima.org/</a></td>
</tr>
<tr>
<td></td>
<td><strong>CalOptima LTSS Authorization Department</strong></td>
</tr>
<tr>
<td></td>
<td><strong>P.O. Box 11045</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Orange, CA 92856</strong></td>
</tr>
</tbody>
</table>

**CalOptima Long-Term Services and Supports Mailing Address**
# AUTHORIZATION PROCESS QUICK REFERENCE GUIDE

## Initial Request

<table>
<thead>
<tr>
<th>Description</th>
<th>Forms/Resources</th>
<th>Timing Requirements</th>
<th>Reference in Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization</td>
<td>LTC ARF Section I–V completed by facility and signed by an MD</td>
<td>No later than 21 calendar days after admission or change of payer</td>
<td>LTC ARF Completion Instructions&lt;br&gt;Level of Care Criteria&lt;br&gt;PASRR&lt;br&gt;Completion Instructions</td>
</tr>
<tr>
<td></td>
<td>Electronic PASRR (DHCS 6170 form)</td>
<td>Orange County facilities must fax a list of names for members whose LTC ARFs meet the 21-day requirement before the next on-site visit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum Data Set (MDS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare/ HMO denial</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary insurance denial (Medicare or other insurance denial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sufficient chart documentation to justify the level of care requested</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For subacute additional documents required:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DHCS 6200-A (Adult) or DHCS 6200 (Pediatric)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For ICF, ICF/FF, ICF/DD-H, ICF/DD-N facilities submit only HS 231 form signed by RCOC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Reauthorization Request

<table>
<thead>
<tr>
<th>Description</th>
<th>Forms/Resources</th>
<th>Timing Requirements</th>
<th>Reference in Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization</td>
<td>LTC ARF Section I completed by facility</td>
<td>Present up to 60 days prior to the expiration of the current active LTC ARF for SNF NF-A and NF-B, ICF/DD, ICF/DD-H, ICF/DD-N facilities but no less than 24 hours before the current authorization expires.</td>
<td>LTC ARF Completion Instructions&lt;br&gt;Level of Care Criteria&lt;br&gt;PASRR&lt;br&gt;Completion Instructions</td>
</tr>
<tr>
<td></td>
<td>Minimum Data Set (MDS)</td>
<td>Up to 30 days prior to the expiration date of the current active LTC ARF for subacute facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level II PASRR Notice of Determination DMH/DDS (if required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sufficient chart documentation to justify level of care requested</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>For subacute additional documents required:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DHCS 6200-A (Adult) or DHCS 6200 (Pediatric)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For ICF, ICF/FF, ICF/DD-H, ICF/DD-N facilities submit only HS 231 form signed by RCOC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Retroactive Request

<table>
<thead>
<tr>
<th>Description</th>
<th>Forms/Resources</th>
<th>Timing Requirements</th>
<th>Reference in Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization</td>
<td>LTC ARF Sections I-V completed by facility and signed by an MD</td>
<td>Present LTC ARF within 120 calendar days of the State of California’s eligibility determination. The facility is responsible to check eligibility two times a month.</td>
<td>LTC ARF Completion Instructions&lt;br&gt;Level of Care Criteria&lt;br&gt;PASRR Completion Instructions</td>
</tr>
<tr>
<td></td>
<td>Electronic PASRR (DHCS 6170 form)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum Data Set (MDS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare/ HMO denial</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary insurance denial</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sufficient chart documentation to justify the level of care requested</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Authorization Request Treatment in Place

<table>
<thead>
<tr>
<th>Description</th>
<th>Forms/Resources</th>
<th>Timing Requirements</th>
<th>Reference in Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does Not Require Authorization, (but does require notification)</td>
<td>OneCare Connect CalOptima Community Network (CCN) members only Use LTC Treatment in Place Notification Form.</td>
<td>Nursing Facility (NF) notifies LTSS within 24 hours of start date of services, or the next business day by telephone or facsimile. Does not require prior authorization.</td>
<td>LTC Treatment in Place Notification Form&lt;br&gt;Completion Instructions</td>
</tr>
</tbody>
</table>

### Bed Hold/ LOA-Request

<table>
<thead>
<tr>
<th>Description</th>
<th>Forms/Resources</th>
<th>Timing Requirements</th>
<th>Reference in Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization</td>
<td>LTC ARF Section I completed by facility. MD order with dates of services, name of general acute care facility member is transferring to and “Bed hold” clearly documented in the order. Must be written on day of transfer to acute care facility. Member or Member’s authorized representative must request the nursing facility hold the bed.</td>
<td>Must be listed on the 21-Day List before the end of 21 days of return to the nursing facility holding the bed. Bed hold ends on the day the member returns to the facility, changes to other payer or does not return before day 8.</td>
<td>LTC ARF Completion Instructions</td>
</tr>
</tbody>
</table>
# Discharge Notification

<table>
<thead>
<tr>
<th>Description</th>
<th>Forms/Resources</th>
<th>Timing Requirements</th>
<th>Reference in Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization</td>
<td>Discharge Disposition Form with Community PCP name, address and phone (when member discharged to community)</td>
<td>Within one business day of discharge.</td>
<td>LTC ARF Completion Instructions</td>
</tr>
<tr>
<td></td>
<td>Post-discharge plan (when member discharged to community)</td>
<td></td>
<td>Discharge Notification</td>
</tr>
<tr>
<td></td>
<td>Discharge Notification Form (MC 171) applicable for NF and SNF only</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed by the nursing facility staff.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
G2: INITIAL AUTHORIZATION: SKILLED NURSING FACILITIES (SNF), NURSING FACILITY LEVEL A (NF-A) AND LEVEL B (NF-B)

CIRCUMSTANCES REQUIRING A CALOPTIMA LONG-TERM CARE (LTC) AUTHORIZATION REQUEST FORM (ARF):

1. The CalOptima member is a new admission to the facility.
2. The CalOptima member has exhausted Medicare benefits.
3. There is a Medicare, facility or other insurance denial.
4. The member has had a readmission from general acute care hospital (did not return on day number eight).
5. The member returns from an approved leave of absence beyond the approved time period allowed.
6. The resident has become a CalOptima member while residing in the facility. This can be either:
   a. A new Medi-Cal beneficiary
   b. An existing Medi-Cal beneficiary whose county of eligibility has changed from another county to Orange County (CalOptima). Please review the section of this manual pertaining to member eligibility for more specific eligibility guidelines.
7. When the CalOptima health plan is no longer responsible for a short stay.

Process to Obtain a CalOptima LTC Authorization

Note: Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

Authorization: Complete sections I, II, III, IV and V of the LTC ARF, including physician signature and documentation to support the level of care requested, and present to CalOptima NCM during the scheduled on-site visit.

The CalOptima LTC ARF must be presented with the following documentation for adjudication:

   a. A complete and accurate electronic Preadmission Screening Resident Review (PASRR) DHCS 6170 form on or before the day of member’s admission to the facility
   b. Medicare, facility or other insurance denial, if appropriate
   c. Minimum Data Set (MDS) and sufficient chart documentation to support the medical necessity for the level of care requested
   d. Proof (via time stamp) that the member’s name and admission date was entered on the 21-Day List (before the end of 21 days in the NF) and faxed to CalOptima LTSS department as notification of the admission.
   e. If the member’s name and admission date were not placed on the 21-Day List as required but meets level of care criteria, a 15 percent payment reduction will be assessed from day one until the member’s name and admission date were placed on the 21-Day List. The 21-Day List must be presented to the LTC NCM at the time the onsite visit.
   f. Authorization and payment is based upon the level of care determination.

Final Adjudication: After review, the on-site nurse will adjudicate the LTC ARF during a scheduled facility visit or via a fax process when the NF is a “fax-in” building due to low CalOptima census. If the LTC ARF is
approved, a copy of the approval letter will be faxed with LTC ARF reference number.

**Authorization Periods:** Initial authorizations will usually be granted for a four-month period of time. During this time, the Level II PASRR will be completed by the Department of Mental Health, if necessary, allowing the facility to complete a thorough evaluation for discharge planning. Note: Four months allows for a re-evaluation of the member’s needs and is NOT to be considered a denial of services by CalOptima.

**Note:** For easier coordination of care, out-of-county facilities are encouraged to work with member or responsible party to transfer benefits to the facility’s county if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

### CalOptima Policies and Procedures:

- GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
- GG.1804: Admission to, Continued Stay in or Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
- GG.1806: Preadmission Screening and Resident Review (PASRR)
- GG.1807 Authorization Review Process, Long Term Care

### For OneCare Connect Community Care Network (CCN)

#### Treatment in Place

Treatment in place services prevent avoidable emergency department (ED) visits and acute hospital admissions for CalOptima members residing in long-term care (LTC) facilities who are enrolled in CalOptima Community Network (CCN) for the OneCare Connect program.

**CIRCUMSTANCES REQUIRING A CALOPTIMA TREATMENT IN PLACE (TIP) AUTHORIZATION REQUEST:**

A. When a member who is residing in an LTC NF becomes acutely ill, the LTC primary care provider (PCP) or physician designee may determine if the member can be safely treated at the NF, write the order for TIP and specify the estimated length of stay.

B. The SNF shall:
   1. Complete the LTC Treatment in Place Notification Form
   2. Identify the length of stay (start and end date)
   3. Indicate the level of skilled nursing care as SN2:
      a. Level II, skilled medical and rehabilitation care, revenue code 192
      b. NFs will be paid for treatment in place services based on their specific contracts.
   4. Fax completed LTC Treatment in Place Notification Form (signed by the LTC PCP or nurse practitioner), to CalOptima Long-Term Services and Support (LTSS) at 714-246-8843.

C. CalOptima LTSS department staff shall review the circumstances resulting in the treatment in place being initiated, and complete “Pay and Educate” if any errors have been made by the NF. Prior authorization for treatment in place services is not required. CalOptima LTSS department will not require any authorization for treatment in place services but does require notification within 24 hours of initiation of TIP services.
D. When an extension for TIP is needed, the SNF shall submit a new LTC TIP Notification Form with dates of services and “extension” clearly written on the form. This TIP Notification form shall be submitted to CalOptima’s LTSS department within 24 hours of the extension being initiated.

E. SNF staff shall monitor treatment in place throughout the member’s length of stay and notify CalOptima LTSS department of the following:
   1. If the member has returned to the previous level of care or
   2. If the member has not returned to the previous level of care and needs an extension for treatment in place.

Note: Treatment in place services do not apply to SNF subacute.

**CalOptima Policies and Procedures:**

CMC.1818 Treatment in Place for CalOptima Community Care Network (CCN) Members residing in Long-Term Care Facilities
G3: REAUTHORIZATION — REGULAR: SKILLED NURSING FACILITIES, NURSING FACILITY LEVEL A (NF-A) AND LEVEL B (NF-B)

TIMELINESS REQUIREMENTS FOR REAUTHORIZATION REQUESTS

1. A reauthorization request must be presented prior to the expiration date of the current active Long-Term Care Authorization Request Form (LTC ARF) and may be presented up to 60 days prior to the expiration date of the active LTC ARF.

2. If a reauthorization request is presented late but meets level of care criteria, a 15 percent payment reduction will be assessed from day one until the LTC ARF is presented.

Process for obtaining a reauthorization

Note: Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

1. Authorization: Complete sections I, III, and IV of the LTC ARF, including a physician signature and documentation to support the level of care requested, and present to the CalOptima on-site nurse.

   Final Adjudication: After review, the on-site nurse will adjudicate the LTC ARF during the scheduled facility visit. If the LTC ARF is approved, CalOptima will fax a copy of the approval letter to the facility and an LTC ARF reference number will be given at that time.

2. Authorization Periods: Reauthorization may be granted for up to a two-year time period.

Note: For easier coordination of care, out-of-county facilities are encouraged to work with member or member’s authorized representative to transfer benefits to the facility’s county, if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

CalOptima Policies and Procedures:

GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)

GG.1804: Admission to, Continued Stay in or Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)

GG.1806: Preadmission Screening and Resident Review (PASRR)

GG.1807 Authorization Review Process, Long-Term Care
This process outlines the requirements for reviewing and processing a Long-Term Care (LTC) Authorization Request and criteria for a member’s admission to, continued stay in, or discharge from an Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N).

1. All admissions requiring ICF/DD, ICF/DD-H, or ICF/DD-N levels of service are subject to certification by the Regional Center and the attending physician for placement of all developmentally disabled members.

2. The Regional Center shall determine the facility placement and level of care for a developmentally disabled member.

3. The initial and reauthorization requests shall be initiated by the ICF/DD, ICF/DD-H and ICF/DD-N facilities. All authorization requests must be submitted with a Certification for Special Treatment Program Services (HS 231) form, as required by the Department of Developmental Services (DDS). All members will be approved by the Regional Center prior to submission of the HS 231.

4. The CalOptima Long-Term Services and Supports (LTSS) department shall process all requests for admission to, continued stays in, or discharge from an ICF/DD, ICF/DD-H, or ICF/DD-N pursuant to Title 22, California Code of Regulations (C.C.R.) sections 51343, 51343.1 and 51343.2, as well as the California Department of Health Care Services (DHCS) standard clinical criteria for level of care.

5. When the Regional Center determines a member meets ICF/DD, ICF/DD-H, or ICF/DD-N level of care criteria and authorizes up to two years of service, as documented on HS 231, the CalOptima LTSS department shall document the authorization as requested in the medical management system and provide an authorization number to the admitting facility.

6. CalOptima’s LTSS department will enter a reauthorization into the medical management system when an ICF/DD, ICF/DD-H, ICF/DD-N sends the Regional Center sends the signed HS 231 form with reauthorization information to CalOptima.

7. Upon notification by the facility of a member’s discharge, the CalOptima LTSS department shall close the active LTC authorization effective the day of discharge. The facility shall notify CalOptima within three business days of a member’s discharge by submitting the Discharge Disposition Form.

9. A Member may elect to use their share of cost (SOC) funds to pay for necessary, non-covered medical services or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the member’s attending physician. The medical service is considered a non-covered benefit if one of the following occurs:
   a. The medical service is rendered by a non-Medi-Cal provider; or
   b. The medical service does not meet medical necessity and results in a denial. CalOptima’s Utilization Management department will issue the Notice of Action (NOA) to the ICF facility to include information on a member’s appeal rights, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

**Process for obtaining a CalOptima LTC Authorization:**

**Note:** Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

1. **Authorization:** Fax the following documents to CalOptima:
   a. LTC ARF with section I, II, IV and V completed and signed by the physician
   b. HS 231 form signed by the Regional Center of Orange County (RCOC).

2. If the LTC ARF and the HS 231 forms required attachments, are incomplete or not signed as required, the CalOptima LTSS department shall request the facility resubmit completed required documentation.

3. **Authorization Periods:** Authorization can be for a period of up to two years and is based on the HS 231 form completed and signed by the Regional Center of Orange County (RCOC).

**Note:** There is no on-site authorization process for ICF/DD, ICF/DD-H or ICF/DD-N facilities.

**Note:** For easier coordination of care, out-of-county facilities are encouraged to work with member or responsible party to transfer benefits to the facility’s county if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

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**CalOptima Policies and Procedures**

- GG.1802: ARF Process and Criteria for Admission to, Continued Stay in and Discharge from ICF/DD, ICF/DD-H, ICF/DD-N
- GG.1807 Authorization Review Process, Long-Term Care
G5: Reauthorization: ICF/DD, ICF/DD-H, ICF/DD-N

This section applies to the following CalOptima programs:
Medi-Cal

G5: REAUTHORIZATION: INTERMEDIATE CARE FACILITIES FOR DEVELOPMENTALLY DISABLED (ICF/DD), INTERMEDIATE CARE FACILITIES FOR DEVELOPMENTALLY DISABLED-HABILITATIVE (ICF/DD-H), INTERMEDIATE CARE FACILITIES FOR DEVELOPMENTALLY DISABLED-NURSING (ICF/DD-N)

TIMELINESS REQUIREMENTS FOR REAUTHORIZATION REQUESTS

A reauthorization request must be presented prior to the expiration date of the current active Long-Term Care Authorization Request Form (LTC ARF) and may be presented up to 60 days prior to the expiration date of the active LTC ARF.

PROCESS FOR OBTAINING A REAUTHORIZATION

Note: Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

1. **Authorization:** Fax the following documents to the CalOptima Long-Term Services and Supports (LTSS) Authorization department:
   a. LTC ARF with section I, II, IV and V completed and signed by the physician
   b. The HS 231 form signed by the Regional Center of Orange County (RCOC)

Requesting an extension if the HS 231 is not available:

If the required LTC ARF and the HS 231 forms attached are incomplete or not signed as required, the CalOptima LTSS department shall request the facility resubmit completed required documentation.

1. **Final Adjudication:** The CalOptima LTSS staff will review the submitted LTC ARF. CalOptima’s LTSS department will fax a copy of the approval letter to the facility and an LTC reference number will be given at that time.

2. **Authorization Periods:** Authorization can be for a period of up to two years and is based on the HS 231 form completed and signed by the Regional Center.

Note: There is no on-site authorization process for ICF/DD, ICF/DD-H or ICF/DD-N facilities.

Note: For easier coordination of care, out-of-county facilities are encouraged to work with member or member’s authorized representative to transfer benefits to the facility’s county if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

CalOptima Policies and Procedures:
GG.1802: ARF Process and Criteria for Admission to, Continued Stay in and Discharge from ICF/DD, ICF/DD-H, ICF/DD-N
GG.1807 Authorization Review Process, Long-Term Care
G6: INITIAL AUTHORIZATION — SUBACUTE/ADULT AND PEDIATRIC

CIRCUMSTANCES REQUIRING A CALOPTIMA LONG-TERM CARE (LTC) AUTHORIZATION REQUEST FORM (ARF):

1. The CalOptima member is a new admission to the facility.
2. The CalOptima member has exhausted Medicare benefits.
3. There is a Medicare, facility or other insurance denial.
4. The member has had a readmission from general acute care hospital (did not return on day number 8).
5. The member returns from an approved leave of absence beyond the approved time period allowed.
6. The resident has become a CalOptima member while residing in your facility. This can be either:
   a. A new Medi-Cal beneficiary
   b. An existing Medi-Cal beneficiary whose county of eligibility has changed from another county to Orange County (CalOptima). Please review the section of this manual pertaining to member eligibility for more specific eligibility guidelines.

PROCESS FOR OBTAINING A CALOPTIMA LTC AUTHORIZATION

Note: Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

1. Authorization: Complete section I, II, III, IV and V of the LTC ARF, including physician signature and documentation to support the level of care requested, and present to CalOptima within 21 calendar days.

2. The CalOptima LTC ARF must be presented with the following documentation for adjudication:
   a. A complete and accurate electronic Preadmission Screening (PASRR) DHCS 6170 form on or before the day of member’s admission to the facility
   b. Medicare, facility or other insurance denial, if appropriate
   c. Minimum Data Set (MDS) and sufficient chart documentation to support the medical necessity for the level of care requested
   d. Completed DHCS 6200-A/DHCS 6200 form proof (via time-stamp) that the member’s name and admission date was entered on the 21-Day List (before the end of 21 days in the NF) and faxed to CalOptima LTSS department as notification of the admission. If the member’s name and admission date were not placed on the 21-Day List as required but meets level of care criteria, a 15 percent payment reduction will be assessed from day one until the member’s name and admission date were placed on the 21-Day List.
   e. Final Adjudication: After review, the on-site nurse will adjudicate the LTC ARF during the regularly scheduled facility visit. If the ARF is approved, CalOptima will fax a copy of the approval letter to the facility and LTC ARF reference number will be given at that time.
   f. Authorization Periods: Authorizations may be granted for six-month time periods.
Note: For easier coordination of care, out-of-county facilities are encouraged to work with member or responsible party to transfer benefits to the facility’s county if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

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G7: REAUTHORIZATION — SUBACUTE/ADULT AND PEDIATRIC

TIMELINESS REQUIREMENTS FOR REAUTHORIZATION REQUESTS:

1. A reauthorization request must be presented at least 24 hours prior to the expiration date of the current active Long-Term Care Authorization Request Form (LTC ARF) and may be presented up to 30 days prior to the expiration date of the active LTC ARF.

2. If a reauthorization request is presented late but meets level of care criteria, a 15 percent payment reduction will be assessed from day one until the LTC ARF is presented.

PROCESS FOR OBTAINING A REAUTHORIZATION:

Note: Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

1. Authorization: Complete and present the following documents to CalOptima on-site nurse prior to the expiration of the current authorization:
   a. Sections I, III, IV of the LTC ARF, including a physician signature
   b. Documentation to support the level of care requested
   c. Completed DHCS 6200-A (Adults) /DHCS 6200 form (Pediatrics)

If an LTC ARF is presented late but meets level of care criteria, a 15 percent payment reduction will be assessed from day one until the LTC ARF is presented.

2. Final Adjudication: After review, the on-site nurse will adjudicate the LTC ARF during the scheduled facility visit. If the LTC ARF is approved, CalOptima will fax a copy of the approval letter to the facility and an LTC ARF reference number will be given at that time.

3. Authorization Periods: Reauthorization may be granted for up to a six-month time period.

Note: For easier coordination of care, out-of-county facilities are encouraged to work with member or responsible party to transfer benefits to the facility’s county, if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

CalOptima Policies and Procedures:

GG.1803: ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility- Adult/ Pediatric

GG.1804: Admission to, Continued Stay in or Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)

GG.1807 Authorization Review Process, Long-Term Care
G8: RETROACTIVE ELIGIBILITY: AUTHORIZATION AND PROCESS GUIDELINES

DETERMINING RETROACTIVE ELIGIBILITY:

1. CalOptima does not make eligibility determinations. Refer to the eligibility section of this manual for specific eligibility guidelines.

2. LTC ARF requests are due within 120 calendar days of the State of California’s eligibility determination regardless of when the provider identifies eligibility.

3. Facilities are advised not to wait for a Notice of Action (NOA) to identify retroactive eligibility. Follow the process for obtaining a CalOptima LTC Authorization as outlined in Policy and Procedure GG.1809 Retroactive Authorization Request for Long Term Care Facility.

Note: Always verify CalOptima eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

1. Authorization: Complete sections I, II, III, IV and V of the LTC ARF, including a physician signature and documentation to support the level of care requested. It must be submitted no later than 120 calendar days of the State of California eligibility determination for Medi-Cal or OneCare Connect, regardless of when the facility identifies eligibility. Authorization requests that are submitted after the 120 calendar day requirement shall be subject to a fifteen percent payment reduction.

2. The request must be submitted on the appropriate form and must be presented with the following documentation:
   a. Copy of denial letter or other document is required as applicable:
      - Notice of Action (NOA)
      - Integrated Denial Notice (IDN)
      - Notice of Medicare Non-Coverage (NOMNC)
      - Other Health Care (OHC) Explanation of Benefit
   b. Electronic Preadmission Screening Resident Review (PASRR) Level I Screening Document (initial requests only) (ICF/DD, ICF/DD-H, and ICF/DD-N facilities are exempt)
   c. Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay
   d. Nurse’s notes, Social Services Agency (SSA) evaluations or physician orders if the MDS, does not reflect the need for skilled care placement (ICF/DD, ICF/DD-H, and ICF/DD-N facilities are exempt)
   e. Signed certification of Special Treatment Program Services Form HS 231 for ICF/DD, ICF/DD-H and ICF/DD-N facilities only and
   f. Completed DCHS 6200-A (Adults)/DHCS 6200 (Pediatrics) forms, for subacute facilities.

Authorization and payment is based upon the level of care determination.
Note: For easier coordination of care, out-of-county facilities are encouraged to work with member or member’s authorized representative to transfer benefits to the facility’s county if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

CalOptima Policies and Procedures:
GG.1804: Admission to, Continued Stay in or Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
FF.1806: Preadmission Resident Review Screening (PASRR)
GG.1809 Retroactive Authorization Request for Long Term Care Facility.
G9: BED HOLD AND LEAVE OF ABSENCE: AUTHORIZATION REQUESTS

GENERAL RULES FOR BED HOLD:

1. There must be a physician order for transfer to general acute care hospital and bed hold order written at the same time of the member’s transfer to general acute care hospital.

2. Bed hold requests are payable when the member meets eligibility for Medi-Cal with CalOptima and the member’s stay is being covered by Medicare or Medicare HMO and the member is admitted into a general acute care hospital.

3. If the facility is aware that the member requires greater than seven days of general acute care hospitalization, the facility is not required to hold the bed and shall not bill CalOptima for any remaining bed hold days.

4. Bed hold payment terminates on the member’s day of death.

5. The facility shall be required to hold the bed vacant when requested by the member or member’s authorized representative, unless notified that the member requires more than seven days of general acute hospital care.

6. There are no limits to the number of bed hold episodes. However, the member must remain at the facility at least 24 hours prior to the start of the next bed hold period.

7. Facilities that are receiving payment for contracted beds are not eligible for bed hold reimbursement for those beds.

8. The day of departure from the SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N or subacute facility shall be counted as day one of bed hold.

9. The day of return to the SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N or subacute facility shall be counted as day one of inpatient care.

GENERAL RULES FOR LEAVE OF ABSENCE:

1. Patient plans of care for all CalOptima members in an ICF/DD, ICF/DD-H, or ICF/DD-N, subacute facility-adult or subacute facility-pediatric shall include a provision for leave of absence other than for general acute care hospitalization.

2. Payment for a leave of absence as prescribed by the attending physician may be approved for the following:
   a. A visit with relatives or friends
   b. Outpatient diagnostic or treatment services at a general acute hospital
c. Summer camp for members with developmental disabilities as addressed in the member’s plan of care.

3. Payment for a leave of absence shall be limited to a maximum number of calendar days per calendar year as follows:
   a. Seventy-three days for members receiving ICF/DD, ICF/DD-H, and ICF/DD-N levels of care
   b. Eighteen days for all other members
   c. Up to 12 additional days of leave per year may be approved when the request is in accordance
      with the individual patient plan of care and appropriate for the physical and mental well being of
      the member.
   d. There shall be at least five days of inpatient care provided between each approved leave of
      absence.
   e. These limits are in addition to the acute hospitalization leaves ordered by the attending physician
      for which the facility is reimbursed when holding the patient’s bed (bed hold).

4. Payment shall not be made for any day of leave that exceeds the limits set forth in above.

5. Payment of the facility rate, less raw food cost, may be made for members who are on approved leave of absence.

6. Payment for the entire leave of absence shall be denied if the member is discharged within 24 hours of his/her return from leave.

7. The member’s records maintained at the facility shall indicate the dates and intended destination of the leave of absence.

8. Unauthorized leave by the member and/or failure to return from leave of absence:
   a. If a member fails to return from an overnight leave of absence within the prescribed period,
      he/she is considered absent without leave (AWOL). If a member is AWOL, the facility shall not
      bill for the scheduled day of return or for any additional days until the member returns. The
      facility must submit a new LTC ARF when the member returns.
   b. If a member voluntarily leaves a facility without an authorized leave, he/she is considered
      AWOL. If a member fails to return by midnight on the day that he/she goes AWOL, the facility
      shall not bill for that day or for any additional days until the member returns. The facility must
      submit a new ARF when the member returns.
   c. Being AWOL beyond midnight of the night of leaving constitutes a discharge and requires a new
      authorization.

**PROCESS TO OBTAIN A CALOPTIMA LTC AUTHORIZATION FOR BED HOLD**

1. **Authorization:** Present to the on-site nurse (Orange County facility) or fax to CalOptima (out-of-county
   facility) the following documentation within 21 days of end of bed hold. Bed hold ends on the day the
   member returns to the facility, changes to other payer or does not return before eighth day :
   a. The completed LTC ARF with an X placed in the box marked Bed Hold / LOA. Enter the dates
      of services for the bed hold request.
   b. A copy of the physician’s order to transfer the member to the general acute care hospital and bed
      hold order written at the time of transfer
   c. The member or member’s authorized representative consent or request to hold the bed
   d. Nurse’s notes or other clinical documentation as requested by LTSS staff to validate member’s
      status at the time of the transfer to general acute care hospital.
e. If an LTC ARF for bed hold is presented late, the 15 percent payment reduction does not apply. 
   **There is no payment for a late bed hold request.**

2. **Final Adjudication:** After review, the on-site nurse will adjudicate the LTC ARF during the regularly scheduled facility visit. If approved, CalOptima will fax a copy of the approval letter to the facility and an LTC ARF reference number will be given at that time.

**Note:** For easier coordination of care, out-of-county facilities are encouraged to work with member or responsible party to transfer benefits to the facility’s county, if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

**BED HOLD FOR ONECARE CONNECT MEMBERS**

1. A nursing facility shall hold a bed vacant when requested by a OneCare Connect member or a member’s authorized representative, unless notified in writing by the attending physician that the member requires more than seven days of general acute care hospital.
2. A bed hold for a OneCare Connect member admitted to a general acute care hospital is limited to seven days per hospitalization.
   - The day of departure from the nursing facility shall be counted as day one of bed hold.
   - The day of return to the nursing facility shall be counted as day one of inpatient care.

The member’s attending physician must write a physician order for a discharge or transfer at the time a member requires a discharge or transfer from a nursing facility to an acute care hospital and include an order for bed hold. The written order for bed hold on the electronic health record must match the supported document on paper health record. The date of bed hold must be the same as the admission date to a general acute care hospital.

1. The nursing facility will hold the bed vacant during the bed hold period.
2. If a nursing facility is holding a bed and is notified in writing by the attending physician that the member requires more than seven days of hospital care, the facility shall no longer be required to hold the bed and shall not bill OneCare Connect for any remaining bed hold days.
3. There are no limits to the number of bed hold episodes. However, the member shall remain at the facility at least 24 hours prior to the start of the next bed hold period.
4. OneCare Connect shall pay the nursing facility at the facility daily rate minus the cost of raw food for the bed hold days as established by the California Department of Health Care Services (DHCS).
5. OneCare Connect shall not pay for bed hold days when a member is discharged from a facility that is receiving payment for bed hold within 24 hours after the member’s return from a general acute care hospital.
6. If a member dies while hospitalized, the nursing facility shall terminate the bed hold and OneCare Connect shall not pay the facility for the bed hold for the day of death.
7. The nursing facility shall present the on-site nurse or send the authorization request for bed hold reimbursement to OneCare Connect Long-Term Services and Supports (LTSS) within 21 calendar days after the end of the bed hold.
8. If OneCare Connect LTSS staff receives an authorization request after 21 calendar days after the end of the bed hold, OneCare Connect shall consider the authorization late and shall not reimburse the nursing facility for the bed hold. The fifteen percent payment reduction does not apply to bed hold requests.
9. The bed hold ends on the day the member returns to the nursing facility, reimbursement becomes the responsibility of another payer, or the member does not return before the eighth day.
MEMBER’S MEDICAL RECORD AT NURSING FACILITIES

The member’s medical records maintained at the nursing facility must:

- Indicate the name and the address of the intended destination.
- Have a written physician’s order to transfer the member to the general acute care hospital and a bed hold order written at the time of the transfer.
- Have a start and an end date
- Show physician’s order on electronic health record matches paper health record if facility uses two types of health record

1. OneCare Connect shall not require a nursing facility to submit an LTC Authorization Request Form (ARF) for a member with an active LTC ARF who returns to the facility on or before the eighth day of bed hold, except if the nursing facility holds the bed vacant during the bed hold period.
2. If a member returns after the eighth day, the nursing facility shall consider the member as a new admission. In such cases, the nursing facility shall follow admission procedures as set forth in OneCare Connect Policy GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
3. To receive authorization, the nursing facility shall submit the following information with the LTC ARF within 21 calendar days after the end of the bed hold:
   a. A completed LTC ARF with an “X” placed in the box marked “Bed Hold/LOA” with the dates of service for the bed hold request;
   b. A copy of the physician’s order to transfer the Member to the general acute care hospital and bed hold request written at the time of transfer
   c. The member or member’s authorized representative consent or request for bed hold
   d. The physician’s orders or treatment plan that reflects the Medicare skilled need that qualifies for Medicare reimbursement.

CalOptima Policies and Procedures:
GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
GG.1810: Bed Hold, Long-Term Care
GG.1811: Leave of Absence, Long-Term Care
G10: Deferred LTC ARFs

This section applies to the following CalOptima programs:
Medi-Cal, OneCare, OneCare Connect

G10: DEFERRED LONG-TERM CARE (LTC) AUTHORIZATION REQUEST FORMS (ARF)

LTC ARF DEFERRAL PROCESS: ORANGE COUNTY FACILITY

1. LTSS nurse case manager (NCM) shall make a determination to approve, modify or deny an LTC ARF within five business days from the receipt of information reasonably necessary to make a determination.

2. If LTSS NCM fails to render a decision within the required time frame (five business days), an extension/deferral of 14 calendar days may be granted if either the provider requests the extension/deferral, or LTSS-NCM justifies a need for additional information reasonably necessary to make a determination.

3. CalOptima LTSS department shall send a “delay letter” to grant the provider an extension/deferral of 14 calendar days to submit additional information reasonably necessary to make a determination.

4. The LTC facility may request an extension/deferral by completing the CalOptima Deferred Extension Notification Form within 14 calendar days of date of deferral. A one-time extension/deferral of 14 calendar days may be granted by the LTSS NCM to the provider to submit additional information reasonably necessary to make a determination.

5. LTC ARF deferred by the LTSS NCM shall be reviewed within 14 calendar days from the date of the extension/deferral. LTSS NCM shall re-schedule an on-site visit or can review the deferred LTC ARF as a faxed-in request within the 14 calendar days.

6. In instances where LTSS NCM cannot decide to approve, modify or deny an LTC ARF within the required time frame of 14 calendar days because the LTC NCM is not in receipt of requested information reasonably necessary to make a determination, the LTC ARF shall be considered a denial at the 14th day of the extension/deferral.

7. CalOptima shall send a Notice of Action (NOA) letter to the provider and CalOptima member.

8. The NOA shall specify the services being denied, information requested but not received, and the right to appeal. The provider and CalOptima would then have the right to request an appeal with CalOptima within the appeal time frame as stated in the NOA letter.

LTC ARF DEFERRAL PROCESS: OUT-OF-COUNTY FACILITY

1. If an LTC ARF is deferred, CalOptima LTSS department shall send a “delay letter” to the out-of-county LTC facility to grant the provider an extension/deferral of 14 calendar days to submit additional information reasonably necessary to make a determination.

2. Out-of-county LTC facility shall submit via facsimile or mail the requested additional information reasonably necessary to make a determination to CalOptima LTSS Authorization department within 14 calendar days of ARF deferral date.
3. Upon receiving the additional information, the CalOptima LTSS Authorization department will review requested information and adjudicate the deferred ARF.

4. In instances where LTSS-NCM cannot decide to approve, modify or deny an LTC ARF within the required time frame of 14 calendar days because the LTC NCM is not in receipt of requested information reasonably necessary to make a determination, the LTC ARF shall be considered a denial at the 14th day of the extension/deferral.

5. CalOptima shall send a Notice of Action (NOA) letter to the provider and CalOptima member.

6. The NOA shall specify the services being denied, information requested but not received, and the right to appeal. The provider and CalOptima would then have the right to request an appeal with CalOptima within the appeal time frame as stated in the NOA letter.

CalOptima Policy and Procedure:
GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
GG.1802 Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from ICF/DD, ICF/DD-H, ICF/DD-N
GG.1804: Admission to, Continued Stay in or Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
GG.1807 Authorization Review Process, Long-Term Care
G11: DISCHARGE NOTIFICATION

DISCHARGE DISPOSITION FORM REQUIREMENT:

1. LTC facility shall notify CalOptima LTSS department within 24 hours of member’s discharge from facility utilizing Disposition Form.
2. LTC facility shall assist CalOptima member choose a community primary care provider (PCP) when CalOptima member is being discharged to the community setting.

DISCHARGE NOTIFICATION IS REQUIRED WHEN:

1. CalOptima member does not return from an approved bed hold/leave of absence period, i.e., does not return on the 8th day after a general acute care hospital admission.
2. CalOptima member returns to the facility during the bed hold period, but the stay is covered by another payer, i.e., Medicare/HMO.
3. CalOptima member expires during an approved bed hold.
4. There is a change in payer source without an actual discharge from the facility.
5. CalOptima member returns before the 8th day, but re-admitted under skilled short stay services, even if CalOptima is the payer source (Medicare, HMO, SRG, CalOptima CCN).
6. CalOptima member is discharged to other care facilities during an approved bed hold (community setting, board and care, assisted living, hospice care and CLHF homes).

NOTIFICATION PROCESS:

1. For bed hold discharges, fax a copy of the previously authorized LTC ARF for bed hold with start and end date of the bed hold and Discharge Disposition form 24 hours after member’s discharge.
2. When member is discharged to the community (i.e. board and care, assisted living or home), the facility shall fax the Discharge Disposition form and post-discharge plan of care with the name, address and phone number of the community primary care provider (PCP) 24 hours after member’s discharge.
3. For changes in payer source or when member expires, facility to fax Discharge Disposition form 24 hours after member’s discharge.

Note: Long-term care facilities are required to complete the Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC 171) form, on admission or discharge of a CalOptima member residing in their facilities and send form (MC 171) to appropriate agency.
G12 NURSING FACILITY (NF) A- LEVEL OF CARE CRITERIA
(Defined in Darling v. Douglas Settlement Agreement of 2011)

“Nursing Facility-A (NF-A) Level of Care” is set forth in title 22, sections 51120(a) and 51334(l) of the California Code of Regulations. Regulation sections 51120(a)(l), 51334(l) and 51334(l)(1) shall not be construed to preclude individuals who live in non-medical residential care facilities (board and care facilities), or who live at home, from meeting this level of care.

Title 22, CCR Section 51120(a): Intermediate Care Services

(a) Intermediate care services means services provided in hospitals, skilled nursing facilities or intermediate care facilities to patients who:
   (1) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care
   (2) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness
   (3) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required

(b) With respect to services furnished to individuals under age 65, intermediate care services may include services in a public institution (or distinct part thereof) for intellectual and developmentally disabled persons with related conditions only if:
   (1) The primary purpose of such institution (or distinct part thereof) is to provide a program of health or rehabilitative services for intellectual and developmentally disabled individuals and such institutions meet standards as may be prescribed by the United States Department of Health and Human Services.
   (2) The intellectual and developmentally disabled individual with respect to whom a request for payment is made has been determined to need and is receiving active treatment under such a program.
   (3) Payment for intermediate care services to any such institution (or distinct part thereof) will not be used to displace with federal funds any non-federal expenditures that are already being made for intellectual and developmentally disabled persons.

(c) Intermediate care services do not include:
   (1) Services rendered in accordance with Section 51305, Physician Services; 51306, Optometry Services; 51307, Dental Services; 51308, Chiropractic Services; 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services; 51310, Podiatry Services; 51311, Laboratory, Radiological, and Radioisotope Services; 51312, Prayer or Spiritual Healing; 51313, Pharmaceutical Services and Prescribed Drugs; 51314, Rehabilitation Center Outpatient Services; 51315, Prosthetic and Orthotic Appliances; 51317, Eyeglasses, Prosthetic Eyes, and Other Eye Appliances; 51319, Hearing Aids; 51320, Medical Supplies; 51321, Durable Medical Equipment, except as provided in Section 51321 (h) (4); 51323, Medical Transportation Services; 51325, Blood and Blood Derivatives; 51326, Nurse Anesthetist Services; 51327, Inpatient Hospital Services; 51328, Outpatient Heroin Detoxification Services; 51330, Chronic Hemodialysis; 51330.1, Renal Homotransplantation; 51331, Hospital Outpatient Department Services and Organized Outpatient Clinic Services; 51337, Home Health Agency Services; 51340, Early and Periodic Screening Services; and 51341, Short-Doyle Medi-Cal Provider Services

Section G: Long-Term Care Authorization Process
(2) Other equipment and supplies for which prior authorizations have been granted to other providers by the Medi-Cal Consultant and which are therefore separately billed by other providers of services; nor
(3) Personal care items and services not reimbursable by the California Medical Assistance Program as a medical care service but for which a personal and incidental allowance is provided.

Title 22, CCR Section 51334(1): **Intermediate Care Services.**

Intermediate care services are covered subject to the following:

(a) Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the department that the beneficiary requires this level of care.
   
   (1) An initial treatment authorization request shall be processed for each admission.
   
   (2) An initial authorization may be granted for up to one year from the date of admission.

(b) The request for reauthorization must be received by the appropriate Medi-Cal consultant on or before the first working day following the expiration of a current authorization. When the request is received by the Medi-Cal consultant later than the first working day after the previously authorized period has expired, one day of authorization shall be denied for each day the reauthorization request is late. Reauthorizations may be granted for up to six months.

(c) The Medi-Cal consultant shall deny any authorization request, reauthorization request, or shall cancel any authorization in effect when services or placement are not appropriate to the health needs of the patient. In the case of denial of a reauthorization request or cancellation of authorization, the beneficiary shall be notified in writing of the department’s decision, to deny ongoing services; the provider will be notified simultaneously. If the beneficiary does not agree with the department’s decision, the beneficiary has the right to request a fair hearing pursuant to section 51014.1 herein. If the beneficiary requests a fair hearing within 10 days of the date of the notice, the department will institute aid paid pending the hearing decision pursuant to section 51014.2 herein.

(d) The attending physician must recertify, at least every 60 days, the patient's need for continued care in accordance with the procedures specified by the director. The attending physician must comply with this requirement prior to the 60-day period for which the patient is being recertified. The facility must present proof of this recertification at the time of billing for services rendered.

(e) Prior to the transfer of a beneficiary between facilities, a new initial treatment authorization request shall be initiated by the receiving facility and signed by the attending physician. No transfer shall be made unless approved in advance by the Medi-Cal consultant for the district where the receiving facility is located.

(f) Medi-Cal beneficiaries in the facility shall be visited by their attending physicians no less often than every 60 days. An alternative schedule of visits may be proposed subject to approval by the Medi-Cal consultant. At no time, however, shall an alternative schedule of visits result in more than three months elapsing between physician visits.

(g) There shall be a periodic medical review, not less often than annually, of all beneficiaries receiving intermediate care services by a Medical Review Team as defined in section 50028.2.

(h) Leave of absence from intermediate care facilities is reimbursed in accordance with section 51535 and is covered for the maximum number of days per calendar year as indicated below:

Section G: Long-Term Care Authorization Process
(1) Developmentally disabled patients: 73 days
(2) Patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic and rehabilitative program approved and certified by a local mental health director: 30 days
(3) All other patients: 18 days. Up to 12 additional days of leave per year may be approved in increments of no more than three consecutive days when the following conditions are met:
   (A) The request for additional days of leave shall be in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.
   (B) At least five days’ inpatient care must be provided between each approved leave of absence.

(i) Special program services for the mentally disordered (as defined in chapter 4, division 5, title 22 of the California Administrative Code) provided in intermediate care facilities are covered when prior authorization has been granted by the department for such services. Payment for these services shall be made in accordance with section 51511.1.

(j) A need for a special services program for the mentally disordered is not sufficient justification for a beneficiary to be placed in an intermediate care facility. All beneficiaries admitted to intermediate care facilities must meet the criteria found in paragraph (k) of this section.

(k) A need for a special services program for the developmentally disabled or mentally disordered is not sufficient justification for a beneficiary to be placed in an intermediate care facility. All beneficiaries admitted to intermediate care facilities must meet the criteria found in paragraph (l) of this section.

(l) In order to qualify for intermediate care services, a patient shall have a medical condition that needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his/her ability. As a guide in determining the need for intermediate care services, the following factors may assist in determining appropriate placement:
   (1) The complexity of the patient's medical problems is such that he requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.
   (2) Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of PRN narcotics may not qualify.
   (3) Diet may be of a special type, but patient needs little or no assistance in feeding him/herself.
   (4) The patient may require minor assistance or supervision in personal care, such as in bathing or dressing.
   (5) The patient may need encouragement in restorative measures for increasing and strengthening functional capacity to work toward greater independence.
   (6) The patient may have some degree of vision, hearing or sensory loss.
   (7) The patient may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.
   (8) The patient may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.
   (9) The patient may be occasionally incontinent of urine; however, patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the patient has been taught and can care for him/herself.
   (10) The patient may exhibit some mild confusion or depression; however, his/her behavior must be stabilized to such an extent that it poses no threat to him/herself or others.
CalOptima Policy and Procedure:
GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
G13: CRITERIA FOR ADMISSION AND CONTINUED STAY — SKILLED NURSING FACILITY (SNF)

CRITERIA FOR DETERMINING ADMISSION TO SKILLED NURSING FACILITY SERVICES (SNF)

Criteria for admission to SNFs are contained in state regulations (Title 22, California Code of Regulations (C.C.R.), and Section 51335) and are applied on a statewide basis. Those criteria for admission and extension of stay (continuing care) are:

A. Need for patient observation, evaluation of treatment plans and updating of medical orders by the responsible physician

B. Need for constantly available skilled nursing services. A patient may qualify for SNF services if the patient’s care involves one or more of the following conditions and weigh in favor of SNF placement:
   1. Dressing of post-surgical wounds, decubitus ulcers, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require SNF care.
   2. Tracheotomy care, nasal catheter maintenance
   3. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for SNF placement.
   4. Gastrostomy feeding or other tube feeding
   5. Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care where such is feasible for the patient. Colostomy care alone should not be a reason for continuing SNF placement.
   6. Bladder and bowel training for incontinent patients

C. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a SNF depending on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a SNF.
   1. Regular observation of blood pressure, pulse and respiration as indicated by the diagnosis or medication and ordered by the attending physician
   2. Regular observation of skin for conditions such as decubitus ulcers, edema, color and turgor
   3. Careful measurement of intake and output as indicated by the diagnosis or medication and ordered by the attending physician

D. If the patient needs medications that cannot be self-administered and requires skilled nursing services for administration of medications, SNF placement may be appropriate for reasons such as the following:
   1. Injections administered during the evening or night shift. If this is the only reason for SNF placement, consideration should be given to other therapeutic approaches or to the possibility of teaching the patient or a family member to give the injections.
   2. Medications prescribed on an as-needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented.
   3. Use of restricted or dangerous drugs, if required more than during the daytime (requiring close nursing supervision)
4. Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities (ICFs).

5. A physical or mental functional limitation.
   a. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of ICFs.
      i. Bedfast patients
      ii. Quadriplegics or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in SNF.
      iii. Patients who are unable to feed themselves
      iv. Patients who require extensive assistance with personal care, such as bathing and dressing
   b. Mental limitations. Persons with a primary diagnosis of mental illness, including intellectual disability (formerly mental retardation), when such patients are severely incapacitated by mental illness and intellectual disability. The following criteria are used when considering the type of facility most suitable for the mentally ill and intellectually disabled person where care is related to the patient’s mental condition.
      i. The severity or unpredictability of the patient’s behavior or emotional state
      ii. The intensity of care, treatment, services or skilled observation that the patient’s condition requires
      iii. The physical environment of the facility, its equipment and qualifications of staff
      iv. The impact of the particular patient on other patients under care in the facility

E. The general criteria identified above are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

CONTINUING CARE DETERMINATIONS

A. Regular Extensions
   1. Extensions of stay in SNFs require reauthorization by the consultant every four months except for those patients who have been identified as “prolonged care” patients (see B below). Regular extensions are based on the same criteria as initial authorizations.

B. Prolonged Care Determinations
   The “prolonged care” classification recognizes that the medical condition of selected patients require a prolonged period of skilled nursing care. The prolonged care classification is intended only to eliminate unnecessary, costly paperwork for both the state and providers of service. Reauthorizations for prolonged care at the SNF level of care are approved for up to two years (per CalOptima Policy). Therefore, all patients are considered regular or non-prolonged care unless the patient meets the criteria for prolonged care.

Medical functional factors of the patient must support a sound professional judgment that a prolonged period of care will be required. The following medical/functional factors shall be used to reach the decision on prolonged care status:
   1. Highest indications of need for prolonged care:
      a. Total or severe incontinence, which despite bowel and bladder training, has failed to improve
      b. Bedridden and/or comatose or semi-comatose states
      c. Conditions which have resulted in quadriplegia, hemiplegia, spasticity, rigidity, and uncontrolled movements, tremors or deformity dependent upon severity or intensity
d. Conditions which require a high degree of prolonged medical nursing support and supervision (depending upon the patient’s ability to participate responsibly in his/her own care). These include complex regimens of oral and/or parenteral medications and diet to control diabetes, cardiac conditions, seizure disorders, hypertension, tumor conditions, obstructive pulmonary conditions, infectious conditions and pain.

e. Conditions that require a high degree of prolonged mechanical nursing support and supervision (depending upon the patient’s ability to participate responsibly in the patient’s own care). These include tracheotomies, gastrostomies, colostomies, catheters, N/G tubes, IPPB machines, irrigation procedures, medicinal installation procedures, dressing changes, and conditions requiring sterile technique.

f. Conditions requiring medical/psychiatric/developmental nursing support and supervision (dependent upon severity and the patient’s ability to participate responsibly in his/her own care). These include extreme confusion and disorientation, inability to communicate, unacceptable physical, sexual or verbally aggressive behavior and anxiety or depression which is secondary to the medical/physical condition (e.g., terminal cancer).

Note: Conditions which are psychogenic, as opposed to organic, are generally considered transitory in nature. They constitute poor justification for authorizing prolonged care.

Important indications of need for prolonged care (usually requiring two or more of the following):

- Conditions outlined in c, d, e and f above, but of lesser severity, intensity or degree than alluded to in Section 1 above.
- Occasional incontinence — on bowel and bladder retraining programs.
- Debilitating conditions including extreme age which indicates a need for preventive nursing care and supervision to avoid skin breakdown, fractured bones, nutritional deficiency or infectious conditions.
- Cases in which the documented history gives clear indication that changes in the status quo will likely lead to levels of care which are more costly to the Medi-Cal program.

4. Supporting indications. The relative importance of factors in this category is determined by the relationship with factors from a and b of 1 above. Any one factor in this category standing alone is not sufficient to establish prolonged care status. However, items in this category will add to the weight of facts to support a finding of prolonged care status.

- Conditions outlined in a and b of 1 above, but of lesser severity, intensity or degree than alluded to in those sections
- Cases in which the documented history and/or diagnosis gives clear indication of progressive incapacitation
- Dependence for activities of daily living — dependent upon degree
- Sensory impairment
- Generalized weakness or feebleness
- Behavioral management problems

**SUBACUTE LEVEL OF CARE — CRITERIA FOR DETERMINING ADMISSION OR EXTENSION OF STAY (CONTINUING CARE)**

Subacute level of care is defined in Title 22, California Code of Regulations (C.C.R.), Section 51 124.5. Authorization shall be based on medical necessity and the lowest cost service in accordance with Title 22, C.C.R., Sections 51003 and 51303.

**Section G: Long-Term Care Authorization Process**
An initial Treatment Authorization Request (TAR) shall be required for each admission. Extensions of stay require reauthorization by the medical consultant every three months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations.

Minimal standards of medical necessity for this level of care include:

A. Physician visits medically required at least twice weekly during the first month and a minimum of at least once every week thereafter
B. 24-hour access to services available in a general acute care hospital
C. The need for special medical equipment and supplies such as a ventilator, which are in addition to those listed in Title 22, C.C.R., Section 51511 (B)
D. 24-hour nursing is by a registered nurse
E. Any one of the following three items:
   a. A tracheostomy with continuous mechanical ventilation for at least 50 percent of the day
   b. Tracheostomy care with suctioning and room air mist or oxygen as needed and one of the six treatment procedures listed in Section F
   c. Administration of any three of the six treatment procedures listed in Section F

F. Treatment Procedures
   1. Total parenteral nutrition (TPN)
   2. Inpatient physical, occupational and/or speech therapy at least two hours per day, five days per week
   3. Tube feeding (NG or gastrostomy)
   4. Inhalation therapy treatments during every shift and a minimum of four times per 24-hour period
   5. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via heparin lock
   6. Debridement, packing and medicated irrigation with or without whirlpool treatment
G14: LONG-TERM CARE (LTC) AUTHORIZATION REQUEST FORM (ARF) PROCESS AND CRITERIA FOR ADMISSION TO, CONTINUED STAY IN, AND DISCHARGE FROM A NURSING FACILITY LEVEL A (NF-A) AND LEVEL B (NF-B)

OVERVIEW

CalOptima’s Long-Term Support Services (LTSS) department shall process all requests for admission to, continued stay in, or discharge from a Nursing Facility Level A (NF-A) and/or Level B (NF-B) pursuant to the Department of Health Care Services (DHCS) standard clinical criteria for level of care.

OneCare Connect shall approve authorization requests to nursing facilities (NFs) if NFs are licensed by the California Department of Public Health (CDPH), meet acceptable quality standards, and the NFs and CalOptima agree to Medi-Cal rates in accordance with CalOptima Policy EE.1135: Long-Term Care Facility Contracting.

1. The member must be age 21 or older.
2. Services provided by any category of intermediate care facility for the developmentally disabled shall not be considered LTSS.

   a. A nursing facility (NF) shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) (Sections I through V), Minimum Data Set (MDS), Provider Utilization Committee Determination (Medicare or other insurance denial) as appropriate, and electronic Preadmission Screening Resident Review (PASRR) Screening Level I DHCS 6170 and proof (via time-stamp) that the member’s name and admission date was entered on the 21-Day List (before the end of 21 days in the NF) and faxed to CalOptima LTSS department as notification of the admission.

   If the member’s name and admission date were not placed on the 21-Day List as required but meets level of care criteria, a 15 percent payment reduction will be assessed from day one until the member’s name and admission date were placed on the 21-Day List. The rate of reduction is established by OneCare Connect and shall be adjusted periodically, based on the LTC Facilities Annual Financial Reporting data from the California Office of Statewide Health Planning and Development (OSHPD).

   b. OneCare Connect may decide, at its discretion, to perform an on-site level of care review of an LTC ARF. This review shall include an assessment of the member and review of the medical orders, member care plan, therapist treatment plan, NF’s multidisciplinary team notes or other clinical data to assist OneCare Connect staff in making an appropriate determination on the authorization request.

   i. The NF shall submit a reauthorization request of an LTC ARF to the CalOptima LTSS department 24 hours prior to the expiration of the active LTC ARF. The facility may submit a reauthorization LTC ARF up to 60 calendar days prior to the expiration of the active LTC ARF. The requests shall include a completed LTC ARF (Sections I, III, IV and V) signed by a physician, most recent Quarterly Assessment MDS, and sufficient documentation to justify the level of care and continued stay.

Section G: Authorization Process for Long-Term Care
ii. OneCare Connect shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Manual of Criteria for Medi-Cal Authorizations.

iii. The LTC ARF request may be initiated either by the NF case manager or discharge planner, nurse or business office manager.

iv. If the LTC ARF and required attachments are incomplete, CalOptima LTSS department shall defer and return the incomplete LTC ARF and attachments to the facility for review and resubmission. The facility shall resubmit the LTC ARF within 14 calendar days after initial submission of the initial LTC ARF. The LTC ARF shall be subject to denial should the facility not comply with the set timelines. CalOptima OneCare Connect may extend a deferral for 14 days only via an Extension Request form. Should CalOptima LTSS department be unable to approve the LTC ARF due to insufficient documentation of medical necessity, CalOptima LTSS department shall submit the LTC ARF and accompanying documentation to the OneCare Connect medical director or authorized physician designee for review and determination.

v. If the OneCare Connect medical director or designee approves the LTC ARF, CalOptima LTSS department shall send a copy of the approved LTC ARF to the facility.

vi. If the OneCare Connect medical director or designee denies the LTC ARF, CalOptima LTSS department shall notify the facility, member or the member’s authorized representative, and the attending physician in accordance with CalOptima Policy GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial, Modification, or Recommendation and Policy GG.1508: Authorization and Processing of Referrals.

vii. When the NF submits a member’s name to the 21-Day list within the required time frame and the member meets the medical criteria to be under NF-A or NF-B nursing care, OneCare Connect shall approve the LTC ARF retro authorization to the date of the admission.

viii. Should the NF submit the member for review via the 21-Day list later than the 21-calendar day submission period, and OneCare Connect approves the LTC ARF, OneCare Connect shall subject the LTC ARF to a 15 percent payment reduction from the date of the member’s admission up to the date on which the CalOptima LTSS department received the notification of member’s admission to the Nursing Facility.

ix. Upon receipt of an LTC ARF modification or denial, the facility shall have the ability to file an appeal or complaint in accordance with CalOptima Policy GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial, Modification, or Recommendation.

x. Upon notification by a facility of member discharge, OneCare Connect shall close the active LTC ARF, effective the day of discharge.
**CalOptima Policies and Procedures:**

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<th>Policy</th>
<th>Description</th>
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<td>Authorization and Processing of Referrals</td>
</tr>
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<td>GG.1800</td>
<td>ARF Process &amp; Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)</td>
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<td>EE.1135</td>
<td>Long-Term Care Facility Contracting</td>
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</tbody>
</table>
This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

H1: DETERMINING WHICH CLAIMS PROCESS APPLIES

Where a provider files a claim for payment determining which claims processing guidelines apply depends upon whether the member is in a health network or CalOptima Direct, as well as the type of health network. Each CalOptima health network and CalOptima Direct has its own claims processing function.

As a result, it is essential that a provider identify the member’s network affiliation prior to submitting a claim for the member. This affiliation determines where the provider will file the claim, as well as the claims processing procedural guidelines that apply.

HOW TO DETERMINE THE APPLICABLE CLAIMS PROCESS

1. **Verify the member’s eligibility** and determine whether member is in CalOptima Direct/CalOptima Community Network, a shared risk group (SRG) health network, an health maintenance organization (HMO) or physician hospital consortium (PHC) health network. For more information on verifying a member’s eligibility, see Section E1: Verifying Member Eligibility.

2. **HMO or PHC Health Network Members** — If the member belongs to a health network that is an HMO or (PHC, the provider should file claims with the member’s health network and follow the health network’s claims processing guidelines.

3. **SRG Health Network Members** — If the member belongs to a health network that is an SRG, the provider should file professional claims with the SRG health network and follow the SRG’s claims processing guidelines. Providers should file facility claims and most ancillary claims with CalOptima and follow CalOptima’s claims processing guidelines for those claims.

4. **CalOptima Direct/CalOptima Community Network Members** — If the member belongs to CalOptima Direct, the provider will file all claims with the CalOptima Claims department and follow CalOptima’s claims processing guidelines.

Billing Addresses — To obtain the applicable billing addresses, please use the table below:

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<th>Facility Claims</th>
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(See Section H4 of this manual for details) | Electronic Claims: Emdeon or Office Ally  
(See Section H3 of this manual for details)  
Hard Copy Claims: OneCare Connect Claims  
P.O. Box 11065  
Orange, CA 92856  
(See Section H4 of this manual for details) |
| AMVI Care Health Network | AMVI Care Health Network  
1920 East 17th Street, Suite 200  
Santa Ana, CA 92705 | AMVI Care Health Network  
P.O. Box 260350  
Encino, CA 91426 |
| CHOC Health Alliance     | Rady's Children’s Hospital San Diego  
Attn: CHOC/CPN Claims  
3020 Children’s Way, Mail Code 5144  
San Diego, CA 92123 | Rady's Children’s Hospital San Diego  
Attn: CHOC/CPN Claims  
3020 Children’s Way, Mail Code 5144  
San Diego, CA 92123 |
| Family Choice Health Network | Family Choice Health Network  
P.O. Box 260830  
Encino, CA 91426 | Family Choice Health Network  
P.O. Box 260830  
Encino, CA 91426 |
| HPN-Regal Medical Group  | Regal Medical Group  
P.O. Box 371330  
Reseda, CA 91337 | Regal Medical Group  
P.O. Box 371330  
Reseda, CA 91337 |
| Kaiser Permanente        | Kaiser Permanente  
P.O. Box 7102  
Pasadena, CA 91109-7102  
Attn: Claims Administration | Kaiser Permanente  
P.O. Box 7102  
Pasadena, CA 91109-7102  
Attn: Claims Administration |
| AltaMed Health Services  | AltaMed Health Services  
P.O. Box 261790  
Encino, CA 91426 | Electronic Claims: Emdeon or Office Ally  
(See Section H3 of this manual for details)  
Hard Copy Claims: CalOptima Direct Claims  
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<tr>
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<td>Electronic Claims: Emdeon or Office Ally (See Section H3 of this manual for details)</td>
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<td>Hard Copy Claims: CalOptima Direct Claims P.O. Box 11037 Orange, CA 92856 (See Section H4 of this manual for details)</td>
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### Health Network

**Talbert Medical Group**
- Talbert Medical Group
  - P.O. Box 25074
  - Santa Ana, CA 92799
  - Attn: Claims

**United Care Medical Group**
- United Care Medical Group
  - P.O. Box 370940
  - Reseda, CA 91337

### Professional Claims
- Talbert Medical Group
  - P.O. Box 25074
  - Santa Ana, CA 92799
  - Attn: Claims

- United Care Medical Group
  - P.O. Box 370940
  - Reseda, CA 91337

### Facility Claims
- **Electronic Claims:**
  - Emdeon or Office Ally
  - (See Section H3 of this manual for details)

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  - Orange, CA 92856
  - (See Section H4 of this manual for details)

- **Electronic Claims:**
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  - (See Section H3 of this manual for details)

- **Hard Copy Claims:**
  - CalOptima Direct Claims
  - P.O. Box 11037
  - Orange, CA 92856
  - (See Section H4 of this manual for details)
H2: CLAIMS PROCESSING OVERVIEW: CALOPTIMA DIRECT AND SHARED RISK CLAIMS

CalOptima’s Claims department processes certain types of claims for services provided to Medi-Cal members, specifically:

- CalOptima Direct fee-for-service claims (professional and facility)
- CalOptima Shared Risk Group (SRG) health network facility claims, as well as some SRG ancillary service claims

SRG health networks are responsible for payment of professional claims. For more information on claims billing, see Section H1: Determining Which Claims Process Applies. Physician hospital consortium (PHC) and health maintenance organization (HMO) health networks are responsible for payment of professional, facility and ancillary claims.

CalOptima recognizes that a key component of quality health care is timely and efficient medical claims processing. CalOptima processes medical claims primarily per Medi-Cal guidelines and utilizes key industry standard codes and guidelines to promote timely and efficient processing of paper and electronic claims. Contained below is a summary description of CalOptima’s claims processing steps.

PROCESSING STEPS

1. **Edits/Audits** — All claims entering the CalOptima Claims department’s processing system are processed on a first-in, first-out basis. Each claim is subject to a comprehensive series of checks called “edits” and “audits.” The checks validate all data information to determine if the claim should be paid, contested or denied. Edit/audit checks include verification of:
   a. Data validity
   b. Prior authorization requirements
   c. Recipient eligibility on date of service
   d. Provider eligibility on date of service
   e. Procedure/diagnosis, and procedure/modifier compatibility
   f. Other insurance coverage or Medicare benefits
   g. Claim duplication

2. **Claims in Pend/Review** — Claims that fail an edit or audit check will “pend” for review by a claims examiner who will identify the reason for the pended status and examine the scanned image of the claim and attachments (if hard copy received). If input errors are detected, the examiner will correct the error and the claim will continue processing. Claims requiring medical judgment will be reviewed by a physician or other qualified medical professional in accordance with the provisions of California Code of Regulations (CCR), Title 22 and policies established by the Department of Health Care Services.

3. **Reimbursement** — Claims that successfully pass the processing cycle will be adjudicated primarily per Medi-Cal guidelines and will be listed on a Remittance Advice indicating payment or the contested/denied reason.

CalOptima Policies and Procedures:

Section H: Claims and Billing Guidelines
FF.2001: Claims Processing for Covered Services Rendered to COD or SRG Members
H3: ELECTRONIC CLAIMS SUBMISSION: CALOPTIMA DIRECT, SHARED RISK, ONECARE (HMO SNP) AND ONECARE CONNECT CLAIMS

CalOptima accepts claims in both electronic and hard copy formats. This section provides information about electronic claims submission, including Electronic Data Interchange (EDI) claims, Pediatric Preventive Services PM160 Form electronic billing, and Long-Term Care (25-1) electronic billing.

For information regarding hard copy billing, see H4: Hard Copy Claims Submission — CalOptima Direct, Shared-Risk, OneCare (HMO SNP), and OneCare Connect Claims.

Note: For Medi-Cal members, the CalOptima Claims department is responsible for processing CalOptima Direct claims, as well as Shared Risk Group (SRG) facility claims and some SRG ancillary claims. The SRGs are responsible for payment of professional claims for their Medi-Cal members. Health Maintenance Organizations (HMO) and Physician Hospital Consortium (PHC) health networks are responsible for payment of professional, facility and ancillary claims for their Medi-Cal members. For more information on claims billing, see Section H1: Determining Which Claims Process Applies.

The OneCare Connect Claims department is responsible for processing claims for facility services rendered to OneCare Connect members. The OneCare Connect health networks are responsible for payment of professional claims for OneCare Connect members. For more information on professional service claims, please see Section H1: Determining Which Claims Process Applies. As a result, the guidance in this section only applies to covered services for which CalOptima is financially responsible.

ADVANTAGES OF ELECTRONIC SUBMISSION

CalOptima strongly encourages electronic claims submission. What are the benefits of submitting claims electronically to CalOptima?

- Electronic claims submission is cost-effective.
- Providers receive an electronic confirmation of claim submission (from the clearinghouse).
- Electronic submission promotes effective utilization of staff resources.

HOW TO SUBMIT ELECTRONIC CLAIMS TO CALOPTIMA

- EDI claims

CalOptima has contracts with data clearinghouses to receive EDI claims. There is no cost to the provider for the services provided by these two clearinghouses. To register and submit electronically, contact one of the vendors listed below:

Emdeon
877-271-0054
www.emdeon.com/
CalOptima Payer Identification Numbers
The following CalOptima payer identification (ID) numbers are to be used when sending claims electronically to CalOptima. (Note that Emdeon and Office Ally have their own payer identification number and each vendor processes different types of claims):

a. **Emdeon: Payer ID “99250”** — For submission of long-term care claims and facility claims (UB)

b. **Office Ally: Payer ID “CALOP”** — For submission of professional (CMS 1500), facility (UB) claims and online PM160 entry

c. **Pediatric Preventive Services** — PM160 (brown form) — For dates of service through June 30, 2018, CalOptima allows providers to submit the PM160 forms electronically through Office Ally’s web portal service. You may submit the PM160 form in accordance with the billing requirements and fields on the PM160. To register for Office Ally web portal services, contact Office Ally at the phone number referenced above.

d. **Long-Term Care Services — (25-1 Form Electronic Billing)** — CalOptima contracts with Emdeon to provide electronic billing for long-term care claims in accordance with the billing requirements and fields on the 25-1 form. To register for long-term care (25-1 form) electronic billing, contact Emdeon at the phone number referenced above.

**REMEMBER ABOUT TIMELY FILING**

CalOptima has timely filing guidelines that allow the provider one year from the date of service to submit a claim. If a claim is not submitted within the appropriate time frame, the claim will be denied. The claim may be submitted for reconsideration with documentation showing that the claim was submitted timely (e.g., retro eligibility issue).

**CHECKING THE STATUS OF A CLAIM ONLINE**

Providers can view claims status and/or check status on CalOptima Link on CalOptima’s website at [www.caloptima.org/](http://www.caloptima.org/).

New users need to register with CalOptima Link. Follow the instructions for checking the status of a claim or a check. For more information on verifying a member’s eligibility, see Section E1: Verifying Member Eligibility.

**GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS**

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8885** Monday through Friday, from 8 a.m. to 12 p.m. and 12:30 to 4 p.m.
H4: Hard Copy Claims Submission: COD, Shared Risk, OneCare (HMO SNP), and OCC Claims

This section applies to the following CalOptima programs:
- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

H4: HARD COPY CLAIMS SUBMISSION: CALOPTIMA DIRECT, SHARED RISK, ONECARE (HMO SNP), AND ONECARE CONNECT CLAIMS

CalOptima accepts claims in both electronic and hard copy formats. This section provides information about hard copy claims submission, including guidelines for how to complete the claim form, important tips and relevant billing addresses.

For information regarding electronic billing, refer to H3: Electronic Claims Submission — CalOptima Direct, Shared-Risk, OneCare (HMO SNP), and OneCare Connect Claims.

Note: The CalOptima Claims department is responsible for processing CalOptima Direct claims, as well as Shared Risk Group (SRG) facility claims and some SRG ancillary claims. The SRGs are responsible for payment of professional claims for their Medi-Cal members. Health Maintenance Organization (HMO) and Physician Hospital Consortium (PHC) health networks are responsible for payment of professional, facility and ancillary claims for their Medi-Cal members. For more information on claims billing, see Section H1: Determining Which Claims Process Applies. As a result, the guidance in this section only applies to covered services for which CalOptima is financially responsible.

GUIDELINES FOR HARD COPY CLAIMS SUBMITTED TO CALOPTIMA

This section explains the basic billing guidelines required for CalOptima processing of hard copy medical CMS 1500 and UB04 claim forms. For more information on how to complete the CMS 1500 and UB04 claims forms, refer to the Department of Health Care Services (DHCS) website at www.dhcs.ca.gov.

Following these guidelines helps ensure that CalOptima can pay a provider’s hard copy claim quickly and accurately:

1. **Type in Designated Area Only**
   All claims are scanned, so it is important that providers input data on the claim form only in the designated fields. Be sure the data falls completely within the text space and is properly aligned. This will ensure that claims are scanned accurately and avoid rejections or payment delays.

2. **Use Alpha or Numeric Characters Only**
   Use only alphabetical letters or numbers in data entry fields as appropriate. Symbols such as “$, #, cc, gm” or positive (+) and negative (−) signs may be used when entering information in the Specific Details/Explanation/Remarks or the Reserved for Local Use fields of the claim form only.

3. **Do Not Use Highlighting Pens**
   Please do not highlight information. When the form and attachments are scanned on arrival at CalOptima, the highlighted area will show up as a black mark, covering the information highlighted.

4. **Follow the Date Format**
   Enter dates in the six-digit format (MMDDYY) without slashes. Refer to the sections of this manual covering claims form completion for appropriate billing form instructions and for additional date format
5. **Cover Corrections**
   Do not strike over errors; do not use correction fluid; do not use correction tape.

6. **Be Sure to Reference Claim Fields or Procedures on Attachments**
   Attached documents for medical claim forms and Provider Dispute Resolution forms should clearly reference the claim field number or procedure that requires additional documentation.
   a. The claim field number on the attachment should be legible, underlined or circled in black ballpoint pen. Allow adequate line space between each claim field number description.
   b. Attach undersized documentation to an 8 1/2 x 11-inch sheet of 20 lb. white bond paper with non-glare tape. Cut oversized attachments in half (e.g., Explanation of Medicare Benefits, Medicare Remittance Notice, Remittance Advice), and tape each half to a separate 8 1/2 x 11-inch white sheet of paper; staple attachments in the top right corner of the form.

   Note: Do not highlight or use tape to fasten attachments to the claim form. Do not use the original claim as an attachment since it may not be interpreted as an original claim. Carbon copies of documentation are not acceptable.

**OTHER IMPORTANT TIPS WHEN SUBMITTING BILLS TO CALOPTIMA**

1. **Timely Filing**
   CalOptima has timely filing guidelines that allow the provider one year from the date of service to submit a claim. If a claim is not submitted within the appropriate time frame, the claim will be denied. The claim may be submitted for reconsideration with documentation showing that the claim was submitted timely (e.g., retro eligibility issue).

2. **Paper Claims and Submission**
   When submitting paper claims to CalOptima, providers should send the original claim form and retain a copy for their records.

3. **Submission Standards**
   Providers should not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.

4. **Unacceptable Forms**
   Carbon copies, photocopies, facsimiles or forms created on laser printers are not acceptable for claims submission and processing.

5. **Point of Service (POS) Printouts**
   Point of Service (POS) printouts, with Eligibility Verification Confirmation (EVC) numbers, are not required attachments unless the claim is over one year old.

**HARD COPY CLAIMS SUBMISSION TO CALOPTIMA**

To submit a claim in hard copy format for CalOptima Direct, or Shared-Risk Medi-Cal members, submit claims to CalOptima using the address below:

**Original Claims**
CalOptima Claims Department
P.O. Box 11037
To submit a claim in hard copy format for members enrolled in OneCare Connect through the health networks or CalOptima, please use the address below:

CalOptima OneCare Connect
P.O. Box 11065
Orange, CA 92856

CHECKING THE STATUS OF A CLAIM ONLINE
Providers can view claims status and/or check status on the CalOptima Link located on CalOptima’s website at www.caloptima.org/. New users will need to register with CalOptima Link. Follow the instructions for checking the status of a claim or a check.

For more information regarding CalOptima Link, see Section E1: Verifying Member Eligibility.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS
For more complex claims questions, contact the Claims Resolution Unit at 714-246-8885 Monday through Friday, from 8 a.m. to 12 p.m. and 12:30 to 4 p.m.

CalOptima Policies and Procedures:
- FF. 2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group
- MA.3101: Claims Processing
This section applies to the following CalOptima programs:

OneCare (HMO SNP),
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

H5: SUBMITTING CROSSOVER CLAIMS

A Crossover claim is one in which the member is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim, and bills Medi-Cal for the remaining balance (which is applied to the deductible and/or coinsurance). For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, may be paid by Medi-Cal. Medi-Cal’s reimbursement is limited, when combined with the Medicare payment and should not exceed Medi-Cal’s maximum allowed for similar services.

A claim billed to CalOptima for the Medicare deductible and/or coinsurance is called a crossover claim

Note: Claims for Medi-Cal covered services provided to Medi-Medi members should be filed directly with CalOptima according to the CalOptima Direct claims submission guidelines. For more information on claims billing guidelines, see Sections H3 and H4 of this manual.

After June 1, 2014, all crossover claims will be processed by CalOptima.

HOW TO FILE A CROSSOVER CLAIM

To submit a crossover claim for a Medi-Medi member, please use the address below:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Address for Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Medi Crossover — All Claim Types</td>
<td>Effective June 1, 2014, providers must submit all Crossover Claims to: CalOptima Crossover Claims Unit P.O. Box 11070 Orange, CA 92856</td>
</tr>
</tbody>
</table>
This section applies to the following CalOptima programs:

Medi-Cal

H6: PM160 INFORMATION ONLY FORM — FULL ASSESSMENT BILLING TIPS

All preventive service visits for CalOptima members under age 21 are eligible for additional funding when submitted on a PM160 Information Only form (PM160 INF — brown form) for dates of service through June 30, 2018. For dates of service on or after July 1, 2018, the PM160 Information Only form will no longer be accepted and providers must use the CMS1500 or UB04 claim form for all preventive services.

Please fill out each PM160 INF completely, using the guidelines below. For more specific information, refer to the Providers section of CalOptima’s website.

BILLING TIPS FOR PM160 CLAIMS — FULL ASSESSMENT

1. Required Information Needed for Completing FULL ASSESSMENT Claims
   a. Patient name — first and last
   b. Provider name and address
   c. Birth date
   d. Provider number
   e. Age
   f. Provider signature (signature on file or signature stamp is not acceptable)
   g. Sex
   h. Date signed
   i. Responsible person — name and complete address
   j. Member identification number (check eligibility each time)
   k. Ethnic code
   l. Height (exception: child in wheelchair with appropriate explanation given in comments)
   m. Date of service
   n. Patient visit
   o. Diagnosis code
   p. Type of screen
   q. Tobacco questions answered (all three)

2. Billing Tips for Assessment Portion of Claim:
   a. Column A — If marked, should have a fee, unless appropriate explanation given in comments (e.g., sent to lab, observation, etc.).
   b. Column B — If marked, should not have a fee. The exception is line 12 (TB Mantoux). This can have a fee if in comments it is explained that patient did not return for follow up.
   c. Columns C and D — If marked, must be marked with a follow-up code (listed on claim, numbers are 1–6) and should have a fee, unless appropriate explanation given in comments.
   d. Other Tests — Must have code number and name of test
   e. Column A may not be marked along with Columns C or D for the same line.
   f. Lines 9 and 10 may not be charged for at the same time.

There must be a checkmark on each line 1–12 under one of the columns (A–D) to indicate outcome of procedure.
3. **Billing Tips for Immunization Portion of Claim:**
   a. Immunization code and description required if immunizations were given
   b. Columns A and B — If marked, must have a fee
   c. Columns C and D — If marked, may not have a fee

4. **Billing Tips for Completing the Immunization Section**
   a. Immunization code and description if immunizations were given
   b. Columns A and B — Must have a fee
   c. Check the patient age with the immunization code used
   d. A complete list of immunization codes is available on CalOptima’s website at [www.caloptima.org/](http://www.caloptima.org/).

5. **Claims Submission and Provider Dispute Process**
   a. All pediatric preventive services claims must be submitted for payment to CalOptima for payment. Include Copy 1 (white) and Copy 2 (yellow) with the completed PM160 INF.
   b. Submit PM160 INF claims and provider disputes to:
      
      CalOptima Direct  
      PPS Claims Unit  
      P.O. Box 11037  
      Orange, CA 92856
   
   c. Providers can check eligibility and/or claims status on CalOptima’s website by accessing CalOptima Link through the Providers section.
   d. For instructions on how to complete a PM160 INF claim form, refer to CalOptima’s website at [www.caloptima.org/](http://www.caloptima.org/).
   e. For more complex claims status inquiries or any questions regarding submission of PM160 INF claims, call the PPS Claims Unit at **714-246-8885**.
H7: PM160 INFORMATION ONLY FORM — BILLING TIPS FOR PARTIAL ASSESSMENT AND IMMUNIZATIONS

All preventive service visits for CalOptima members under age 21 are eligible for additional funding when submitted on a PM160 Information Only form (PM160 INF — brown form) for dates of service through June 30, 2018. For dates of service on or after July 1, 2018, the PM160 Information Only form will no longer be accepted, and providers must use the CMS1500 or UB04 claim form for all preventive services.

Please fill out each PM160 INF completely, using the guidelines below. For more specific information, please refer to the Providers section of CalOptima’s website.

PM160 INFORMATION ONLY BILLING TIPS FOR PARTIAL AND IMMUNIZATION ONLY CLAIMS

1. Required Information Needed in Completing IMMUNIZATION SECTION Claims
   a. Patient name — first and last
   b. Diagnosis code
   c. Birth date
   d. Provider name and address
   e. Age
   f. Provider NPI number
   g. Sex
   h. Date signed
   i. Responsible person — name and complete address
   j. Member identification number (check eligibility each time)
   k. Ethnic code
   l. Provider signature (signature on file or signature stamp is not acceptable)
   m. Date of service

2. Billing Tips for Completing the Immunization Section
   a. Immunization code and description are required if immunizations were given.
   b. Columns A and B — Must have a fee

   Check the patient age with the immunization code used. A complete list of immunization codes is available in CalOptima’s Pediatric Preventive Services (PPS) Resources in the Providers section of CalOptima’s website.

3. Claims Submission and Provider Dispute Process
   All pediatric preventive services claims must be submitted to CalOptima for payment. Include Copy 1 (white) and Copy 2 (yellow) with the completed PM160 INF.

   Submit PM160 INF claims and provider disputes to:

   CalOptima Direct
   PPS Claims Unit
   P.O. Box 11037
Orange, CA 92856

a. Providers can check eligibility and/or claims status on the CalOptima Link located on CalOptima’s website at www.caloptima.org/.

b. For instructions on how to complete a PM160 INF claim form, refer to the PPS Resources page located in the Providers section of CalOptima’s website.

c. For more complex claims status inquiries or any questions regarding submission of PM160 INF claims, call the PPS Claims Unit at 714-246-8885.
This section applies to the following CalOptima programs:

Medi-Cal

H8: RETURNED CLAIM NOTIFICATION LETTER — CALOPTIMA DIRECT

A returned claims notification letter indicates that CalOptima has recently received your claim(s) for services rendered to a CalOptima member. This letter indicates the corrections that are required for processing your claim. The checked box indicates the problem with the claim and the box number informs you of the box number on your CMS 1500 or UB04 that needs correction. This letter is accompanied by your claim(s). This letter is not the same as a denial. When these claims are returned to your office, they are not entered into the CalOptima system.

WHAT TO DO IF YOU RECEIVE A RETURNED CLAIMS NOTIFICATION LETTER

1. After you have made the appropriate corrections, submit the claim(s) to the appropriate address. Do not use the Provider Dispute Resolution (PDR) process. This claim will be considered a first-time submitted claim. If you have not made the corrections for each claim, they will again be returned to your office. Do not attach the returned claims notification letter to your claim(s) once corrected.

2. If you receive a rejection letter, correct the claim form after reviewing all indicated problems and send the original hard copy to:

CalOptima Direct
P.O. Box 11037
Orange, CA 92856

CalOptima Direct Returned Notification Letter/Problem Resolution

<table>
<thead>
<tr>
<th>Provider Problems</th>
<th>How to Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider is not actively registered in our system as a CalOptima Direct provider</td>
<td>Contact our Provider Data Management Services (PDMS) department at 714-246-8468.</td>
</tr>
<tr>
<td>Provider is using a different NPI # (other than the NPI # registered with CalOptima)</td>
<td>Contact our Provider Data Management Services (PDMS) Department at 714-246-8468.</td>
</tr>
<tr>
<td>Provider ID # and Federal Tax ID # are not affiliated</td>
<td>Contact our Provider Data Management Services (PDMS) Department at 714-246-8468.</td>
</tr>
</tbody>
</table>
### Section H: Claims and Billing Guidelines

<table>
<thead>
<tr>
<th>Member Problems</th>
<th>How to Avoid</th>
</tr>
</thead>
</table>
| Cannot identify member based on ID submitted | A provider shall verify a member’s eligibility using one of the following eligibility verification systems (For more information on verifying a member’s eligibility, see Section E1: Verifying Member Eligibility).  
   - CalOptima Link located on CalOptima’s website at [www.caloptima.org/](http://www.caloptima.org/)
   - CalOptima’s Interactive Voice Response (IVR) System at **714-246-8540** or **800-463-0935**
   - The state’s Point of Service Device (POS)
   - The state’s Automated Eligibility Verification System (AEVS) at 800-456-2387 |

<table>
<thead>
<tr>
<th>Incomplete/Misc. Claim Form</th>
<th>How to Avoid</th>
</tr>
</thead>
</table>
| Missing required information | Please correct and submit as an original CMS 1500 form.  
**NOTE:** To avoid a delay in payment of your claims, complete all required information. |
H9: OTHER HEALTH COVERAGE

When a member has other health coverage, CalOptima is the payer of last resort. Providers should coordinate benefits for covered services with other programs or entitlements recognizing other health coverage as primary coverage.

Providers should bill the other health coverage (OHC) carrier prior to billing CalOptima. The OHC carrier may reimburse at a higher rate than CalOptima. If a provider receives a partial payment from the OHC carrier, CalOptima may be billed for the balance for benefit/payment consideration as the payer of last resort. The provider must attach a copy of the complete Explanation of Benefits (EOB) from the primary carrier, including descriptions of denied charges.

CalOptima’s reimbursement is the difference between the CalOptima allowable amount and the other health coverage carrier payment.

IMPORTANT REMINDERS REGARDING OHC

1. **Exclusions** — The following are not considered other health coverage:
   a. CalOptima managed care*
   b. Automobile insurance
   c. Life insurance

*Note: CalOptima managed care is not other health coverage. Providers should refer recipients enrolled in CalOptima managed care plans to the plan for treatment unless the provider is authorized to treat under the plan guidelines.

2. **Reporting other health coverage** — State law requires CalOptima providers to notify the Department of Health Care Services (DHCS) if they believe a recipient may be entitled to other health coverage.

   Please call DHCS at 800-952-5294 between 8 a.m. and 5 p.m. to report possible other health coverage, or write to:

   Department of Health Care Services Health Insurance Section
   P.O. Box 1287
   Sacramento, CA 95812-1287

   Please indicate recipient’s name, Social Security number and name of the other health coverage insurance plan.

3. **Nondiscrimination of CalOptima Beneficiaries**

   Under state law, when a provider obtains proof of eligibility, the provider must accept the CalOptima recipient and be bound by the rules and regulations of the CalOptima program. If a provider obtains proof of eligibility that indicates a recipient is eligible to receive services, the provider cannot treat the recipient as private pay because of the recipient’s OHC status. However, if the provider cannot be paid by the recipient’s OHC because the provider does not participate in the recipient’s OHC plan, the
provider should refer the recipient to the OHC for treatment. CalOptima is not liable for OHC covered services if the recipient elects to seek treatment from a provider not authorized by the OHC.

4. Other Health Coverage Cost Sharing
Providers are prohibited from billing CalOptima recipients, or persons acting on their behalf, for any amounts other than the CalOptima co-payment or share of cost. Therefore, if the recipient’s other health coverage requires a co-payment, coinsurance, deductible or other cost sharing, the provider cannot bill the recipient. If the provider bills the other health coverage and the other health coverage denies or reduces payment because of its cost-sharing requirements, the provider may then bill CalOptima. CalOptima will adjudicate the claim, deducting any other health coverage payment amounts.

5. When to Bill Other Health Coverage
When requesting eligibility verification for a recipient with OHC, the CalOptima eligibility verification system returns a message stating a recipient’s scope of coverage. If a recipient’s OHC code is one of the following and the service rendered falls within the recipient’s scope of coverage, the provider must refer the recipient to the health maintenance organization (HMO) or bill the OHC indicated on the eligibility verification message, before billing CalOptima.

**OTHER HEALTH COVERAGE (OHC) CODES CHART**

<table>
<thead>
<tr>
<th>OHC Code</th>
<th>Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Any carrier</td>
</tr>
<tr>
<td>B</td>
<td>Blue Cross of California</td>
</tr>
<tr>
<td>C</td>
<td>Champus (HMO)</td>
</tr>
<tr>
<td>D</td>
<td>Prudential</td>
</tr>
<tr>
<td>E</td>
<td>Aetna</td>
</tr>
<tr>
<td>F</td>
<td>Medicare HMO</td>
</tr>
<tr>
<td>G</td>
<td>General American</td>
</tr>
<tr>
<td>H</td>
<td>Mutual of Omaha</td>
</tr>
<tr>
<td>I</td>
<td>MetraHealth</td>
</tr>
<tr>
<td>J</td>
<td>John Hancock Mutual Life Insurance</td>
</tr>
<tr>
<td>K</td>
<td>Kaiser (HMO)</td>
</tr>
<tr>
<td>OCH Code</td>
<td>Carrier</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>L</td>
<td>Dental-only policies</td>
</tr>
<tr>
<td>M</td>
<td>Multiple coverage (recipient has more than one insurance policy)</td>
</tr>
<tr>
<td>N</td>
<td>None</td>
</tr>
<tr>
<td>O</td>
<td>Override</td>
</tr>
<tr>
<td>P</td>
<td>PHP/HMO</td>
</tr>
<tr>
<td>Q</td>
<td>Undefined</td>
</tr>
<tr>
<td>R</td>
<td>Undefined</td>
</tr>
<tr>
<td>S</td>
<td>Blue Shield of California</td>
</tr>
<tr>
<td>T</td>
<td>Travelers Plan Administrators (only)</td>
</tr>
<tr>
<td>U</td>
<td>CIGNA/Connecticut General/Equicor</td>
</tr>
<tr>
<td>V</td>
<td>Coverage other than those specified (variable)</td>
</tr>
<tr>
<td>W</td>
<td>Great West Life Assurance Co.</td>
</tr>
<tr>
<td>X</td>
<td>Blue Shield of California</td>
</tr>
<tr>
<td>Y</td>
<td>Undefined</td>
</tr>
<tr>
<td>Z</td>
<td>Blue Cross of California</td>
</tr>
<tr>
<td>2</td>
<td>Health Source Provident Administrators</td>
</tr>
<tr>
<td>3</td>
<td>Principal Financial Group/ Principal Mutual</td>
</tr>
<tr>
<td>4</td>
<td>Pacific Mutual Life Insurance</td>
</tr>
<tr>
<td>5</td>
<td>First Health/Alta Health</td>
</tr>
</tbody>
</table>
Unless a provider is an authorized provider of a recipient’s health plan, refer recipients with HMO coverage to the plan for covered treatment, or contact the HMO for a treatment authorization. CalOptima is not liable for the cost of HMO-covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. To establish CalOptima’s liability, the provider must obtain an acceptable denial letter from the HMO.

6. **Scope of Coverage Codes**

The CalOptima eligibility verification system returns the scope of coverage code when coverage information is available to the DHCS. Up to seven codes may be returned. Scope of coverage codes designate the specific service categories covered by the recipient’s health coverage.

### SCOPE OF COVERAGE CODES CHART

<table>
<thead>
<tr>
<th>COV Code</th>
<th>Service Category</th>
<th>Bill On (Claim Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Prescription Drugs/Medical Supplies</td>
<td>Pharmacy Claim Form (30-1) or CALPOS</td>
</tr>
<tr>
<td>L</td>
<td>Long-Term Care</td>
<td>Payment Request for Long-Term Care (25-1)</td>
</tr>
<tr>
<td>I</td>
<td>Hospital Inpatient</td>
<td>UB-04 Claim Form</td>
</tr>
<tr>
<td>O</td>
<td>Hospital Outpatient</td>
<td>UB-04 Claim Form</td>
</tr>
<tr>
<td>M</td>
<td>Medical and Allied Services</td>
<td>CMS-1500 Claim Form</td>
</tr>
<tr>
<td>V</td>
<td>Vision Care Services</td>
<td>Payment Request for Vision Care and Appliances (45-1)</td>
</tr>
<tr>
<td>D</td>
<td>Dental Services</td>
<td>Not applicable to EDS claims</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Coverage for all medical services except for Long-Term Care and Dental</td>
<td>As appropriate</td>
</tr>
</tbody>
</table>
If information about a recipient’s insurance scope of coverage is not available to DHCS, the message “COMPREHENSIVE” is returned from the CalOptima eligibility verification system. This message indicates presumed coverage for all claim types except long-term care and dental. Providers must bill the insurance carrier for all other services before billing CalOptima.

If a recipient has reported multiple insurance policies, the eligibility verification system identifies the name of the other health coverage insurance carrier(s), or the carrier codes if the Automated Eligibility Verification System (AEVS) is accessed.

7. Billing CalOptima After Other Health Coverage
These principles must be followed when billing CalOptima after other health coverage:

a. The other health coverage benefit must be used completely.
b. CalOptima may be billed for the balance, including other health coverage co-payments, other health coverage coinsurance and other health coverage deductibles.
c. CalOptima will pay up to the limitations of the CalOptima program, less the other health coverage payment amount, if any.
d. CalOptima will not pay the balance of a provider’s bill when the provider has an agreement with the other health coverage carrier/plan to accept the carrier’s contracted rate as a “payment in full.”
e. An Explanation of Benefits (EOB) or denial letter from the other health coverage must accompany the CalOptima claim, except for pharmacy providers.
f. The amount, if any, paid by the other health coverage carrier for all items listed on the CalOptima claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any other health coverage payment.

8. Other Health Coverage EOB or Denial Letter

a. When billing CalOptima for any service partially paid or denied by the recipient’s other health coverage, the other health coverage EOB or denial letter must accompany the claim.
b. When a service or procedure is not a covered benefit of the recipient’s other health coverage, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of one year from the date of the original EOB or denial letter.
c. A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient’s name and address and clearly states the benefits not covered.
d. It is the provider’s responsibility to obtain a new EOB or denial letter at the end of the one-year period. Claims not accompanied by proper documentation will be denied.

9. Medicare Coverage

a. Other health coverage code F — Identifies CalOptima recipients who receive benefits from:
   i. Medicare HMO
   ii. Medicare-contracted HMO in lieu of Medicare fee-for-service

Recipients who have CalOptima and Medicare HMO coverage must seek medical treatment through their Medicare HMO. CalOptima is not liable for payment for HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. CalOptima claims for recipients with Medicare HMO coverage are not Medicare/CalOptima crossover claims. Therefore, to bill CalOptima for services not included in the Medicare HMO plan, submit a CalOptima claim accompanied by an Explanation of Benefits (EOB) or denial letter showing either that the Medicare HMO was billed first and partial payment was made or that the Medicare HMO does not cover the service. Most claims for
Medicare/CalOptima Direct recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits.

CalOptima Direct recipients are considered Medicare-eligible if they are 65 years of age or older, blind or disabled, or if the CalOptima Direct eligibility verification system indicates Medicare coverage. If Medicare approves the claim, it must then be billed to CalOptima as a crossover claim at:

CalOptima Crossover Claims Unit
P.O. Box 11070
Orange, CA 92856

For more information about where to submit Medicare crossover claims, please see Section H5: Submitting Crossover Claims.

**BILLING FOR MEDICARE NON-COVERED, EXHAUSTED OR DENIED SERVICES, OR MEDICARE NON-ELIGIBLE RECIPIENTS**

Straight CalOptima claims must be billed directly to CalOptima if any of the following apply:

- The services are not covered by Medicare.
- Medicare benefits have been exhausted.
- Medicare has denied the claim.
- The recipient is not eligible for Medicare.

These are not crossover claims. For billing and timeliness instructions, refer to the UB-04 and CMS 1500 Completion and CMS 1500/UB04 Submission and Timeliness Guidelines.

1. **Medicare Non-Covered Services**
   CalOptima maintains a list of Medicare Non-Covered codes that may be billed to CalOptima Direct claims for Medicare/CalOptima Direct recipients. Do not send these claims to the CalOptima Crossover Unit.

   All services or supplies on a straight CalOptima Direct claim must be included in the Medicare Non-Covered Services charts for direct billing. If a service or supply is not included in the chart, submit the corresponding Medicare Explanation of Medicare Benefits (EOMB) showing the services or supplies that are not allowed by Medicare when billing CalOptima Direct.

2. **Medicare Exhausted Services**
   Physical therapy and occupational therapy for CalOptima Direct patients with Medicare coverage must be billed to the appropriate Medicare carrier or intermediary. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill CalOptima directly and must include a copy of the Medicare EOMB that shows the benefits are exhausted.

3. **After Medicare Benefits Have Been Exhausted**
   These claims must be billed directly to CalOptima Direct on a CMS 1500, including a copy of the Medicare EOMB, showing the benefits that are exhausted.

4. **Medicare Denied Services**
   Medicare denied services should be billed as straight CalOptima Direct claims. To bill for Medicare denied services, follow these steps:
a. Submit an original CMS 1500 (08/05 version only).
b. Complete the claim according to instructions in the CMS 1500 completion instructions.
c. Do not include any Medicare approved services on the claim. The Medicare approved services must be billed separately as a crossover claim, unless contract specifies Medicare rates.
d. Attach a copy of the Medicare EOMB indicating the denial.
e. If the Medicare denial description is not printed on the front of the Medicare EOMB, include a copy of the description from the back of the EOMB or the Medicare manual.
f. Attach a copy of any other health coverage EOB or denial letter if the recipient has cost-avoided other health coverage through any private insurance (refer to the Other Health Coverage Guidelines for Billing section in the DHCS Medi-Cal manual, Part 1). Providers can access a copy of the other health coverage on the CalOptima website at www.caloptima.org/.
g. Do not send these claims to the Crossover Unit.

5. Services Denied When Included in Surgical Fee or Not Separately Payable
CalOptima Direct does not pay for an office visit when Medicare has denied payment because the visit was included in the surgical fee. The surgical fee covers reimbursement of office visits on the same day that surgery is performed and during the follow-up period of the surgical procedure. In addition, CalOptima Direct does not pay for services denied by Medicare because the procedure is a component part of a group of services. CalOptima Direct will deny these claims with RAD code 027: “Services denied by Medicare (included in surgical fee, incidental, or not separately payable) are not payable by CalOptima Direct.”

BILLING TIPS FOR MEDICARE NON-COVERED, EXHAUSTED OR DENIED SERVICES
The following billing tips will help prevent rejections, delays, incorrect payments and/or denials of claims for Medicare non-covered, exhausted or denied services:

1. A single claim form cannot be used when billing for the combination of Medicare-approved or covered services and Medicare non-covered, exhausted or denied services appearing on the same EOMB.

2. Medicare-approved/covered services must be billed as crossover claims according to the instructions in “Hard Copy Submission Requirements of Medicare Approved Services” in this section.

3. Medicare non-covered, exhausted or denied services must be billed to CalOptima Direct. Use the CMS 1500 and attach a copy of the Medicare EOMB for the exhausted or denied services.

4. If a Medicare denial description(s) is not printed on the front of an EOMB that shows a Medicare denied service(s), provider must copy the Medicare denial description(s) from the back of the original EOMB or from the Medicare manual and submit it to CalOptima Direct along with the bill for the Medicare denied service(s). This applies to any service(s) denied by Medicare for any reason.

5. When billing Medicare non-covered, exhausted or denied services for a recipient who has other health coverage through any private insurance, the provider must also bill the other health coverage before billing CalOptima Direct.

BILLING TIPS FOR MEMBERS WITH MEDICARE AND OTHER HEALTH COVERAGE AS PRIMARY INSURANCE
When a recipient has both Medicare fee-for-service and cost-avoided other health coverage, they must bill in the following order:
1. **First**: Bill Medicare for the Medicare-covered services (do not bill as an automatic crossover claim).

2. **Second**: Bill the other health coverage carrier.

3. **Last**: Bill CalOptima Direct. Attach the Medicare Explanation of Medicare Benefits/Medicare Remittance Notice (EOMB) and the other health coverage EOB to the CalOptima claim.

Please note that Pharmacy providers are exempt from the requirement referenced above.

<table>
<thead>
<tr>
<th>CalOptima Policies and Procedures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA.3103: Claims Coordination of Benefits</td>
</tr>
</tbody>
</table>
This section applies to the following CalOptima programs:

- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

H10: COMMON CLAIM DENIALS AND REJECTS — CALOPTIMA DIRECT, SHARED-RISK, ONECARE (HMO SNP), AND ONECARE CONNECT

Claims are often denied for a few fundamental reasons. The table below summarizes the common claim denial reasons, as well as practical billing tips to address the issue causing the denial.

**COMMON CLAIM DENIALS AND REASONS — MEDI-CAL**

<table>
<thead>
<tr>
<th>EOC</th>
<th>DESCRIPTIONS</th>
<th>BILLING TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDD</td>
<td>Duplicate Claim</td>
<td>Claim received for the same member, same services and same date of service. Be sure to check previous payment record (Remittance Advice) before re-billing the original claim. To inquire about the status of a claim, call our Claims Provider Support Unit at 714-246-8885, from 8 a.m. to 4 p.m.</td>
</tr>
<tr>
<td>X18</td>
<td>This is a health network member.</td>
<td>Member is eligible with a CalOptima health network at the time of service. Be sure to check eligibility prior to submitting the claim to CalOptima Direct.</td>
</tr>
<tr>
<td>726</td>
<td>Bill Medicare, send EOMB and claim to EDS</td>
<td>The member’s primary insurance is Medicare. If the service was denied with an appropriate reason by Medicare, send the claim and the EOMB denial to CalOptima Direct. If the service was paid by Medicare, send the EOMB and claim for crossover processing.</td>
</tr>
<tr>
<td>728</td>
<td>Proof of payment/denial required</td>
<td>Member has other health coverage. Proof of payment or denial from the other health coverage is required. To check if member has other health coverage, verify it through AEVS or POS.</td>
</tr>
<tr>
<td>S13</td>
<td>All enroll events are future</td>
<td>Member is not eligible to receive CalOptima benefits for the date of service billed. Verify member eligibility through AEVS or POS.</td>
</tr>
<tr>
<td>748</td>
<td>Claim received after one-year maximum billing limit</td>
<td>Claims must be received by CalOptima within one year from the date on which services were rendered. Be sure to bill timely to avoid timeliness denial. To inquire about the status of a claim, call our Claims Provider Support Unit at 714-246-8885 from 8 a.m. to 12 p.m. and 12:30 p.m. to 4 p.m.</td>
</tr>
</tbody>
</table>
COMMON CLAIMS DENIAL REASONS — ONECARE (HMO SNP) AND ONECARE CONNECT

The OneCare (HMO SNP) and OneCare Connect Claims department is responsible for processing claims for facility services rendered to OneCare (HMO SNP) and OneCare Connect members. This section identifies several common reasons that may cause OneCare (HMO SNP) and OneCare Connect Claims department to deny a claim.

When OneCare (HMO SNP) and OneCare Connect Claims department identifies a claim that may be contested or denied, the Claims department will send a request for additional information to the provider. If the provider does not respond within 45 calendar days of the date of the letter requesting the additional information, the claim will be processed based on the available information.

The table below presents the most common reasons for denying claims when providers do not furnish any additional information. The table includes the claim denial reason code (Explanation of Code/EOC), description of the denial reason, and billing tips to address the underlying issue causing the denial.

<table>
<thead>
<tr>
<th>EOC</th>
<th>DESCRIPTIONS</th>
<th>BILLING TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDD</td>
<td>Duplicate Claim</td>
<td>The claim has been denied because an earlier claim was received for the same member, for the same services and the same date of service. The provider should check the previous payment record (Remittance Advice) before re-billing the original claim. To inquire about the status of a claim, the provider can contact OneCare’s Claims Provider Support Unit at 714-246-8885, Monday through Friday from 8 a.m. to 12 p.m. and 12:30 to 4 p.m.</td>
</tr>
<tr>
<td>XON</td>
<td>No Authorization</td>
<td>The claim has been denied because the service was not authorized. The provider should refer to the member's ID card for authorization requirements.</td>
</tr>
<tr>
<td>MDC</td>
<td>Re-Bill Medicare Codes</td>
<td>The claim has been denied because the claim did not contain the appropriate Medicare code and was billed with the local Medi-Cal code. The provider should re-bill the claim with the appropriate Medicare code.</td>
</tr>
<tr>
<td>G01, G09</td>
<td>Group’s Responsibility</td>
<td>The claim has been denied because it is the responsibility of the member’s health network. While OneCare will route all misdirected claims to the appropriate group, the provider should submit the claim to the member’s health network for payment.</td>
</tr>
</tbody>
</table>
This section applies to the following CalOptima programs:

- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

H11: RECONCILING CALOPTIMA DIRECT, ONECARE (HMO SNP) AND ONECARE CONNECT PAYMENTS

This section provides information on the importance of reconciling CalOptima Direct claims payments to a provider’s records. Providers receiving a CalOptima Direct Remittance Advice Details (RADs) statement should reconcile each claim transaction to their records. In particular:

- Paid claims should be posted to the patient’s account.
- Denied claims or contested claims should be reviewed to identify errors or other discrepancies.
- Negative adjustments should be posted to the appropriate suspense account.

It is important that providers account for each claim, so that the provider can conduct any appropriate follow up. Providers should also be vigilant in adhering to requirements governing claims submission timelines.

TIPS FOR SPECIFIC RECONCILIATION ISSUES

1. Missing Checks
   a. If a check is known to be stolen, call the CalOptima Direct Claims line at 714-246-8885. Provide the representative with all the known details. Submit written notification that a check was stolen. Send the notification to:
      
      CalOptima Direct
      P.O. Box 11037
      Orange, CA 92856

   b. CalOptima Direct will verify that the check has not been presented for payment and will place a stop payment, if appropriate. A replacement check may be issued by CalOptima. Please note that once a “stop” is placed on a check, it will not be honored if presented for payment.
   c. If a check is presumed missing, please allow 10 calendar days from the release date before making an inquiry. After 10 days, contact the CalOptima Direct Claims line at 714-246-8885 and ask for an investigation of the check, or submit written notification of a missing check and include any information regarding the check. Send the notification to the CalOptima Direct address noted above. Please be sure to include a request for the check to be reissued. CalOptima Direct will initiate a search for the check.
   d. If the search shows the missing check was canceled, CalOptima Direct will send a copy of the front and back of the check to the provider.

2. Returned Checks
   a. A check may be returned by a provider or by the U.S. Postal Service as undeliverable. Undeliverable checks are researched for a correct address. If the check remains undeliverable, the check is re-deposited into a suspense account. The claim lines appearing on the re-deposited check are voided to correct history and reduce the 1099 earnings amount.
   b. If the check was re-deposited inadvertently and the claim lines are voided, a provider must re-bill to receive payment, and advise CalOptima of his or her correct address. The provider should contact the Provider Data Management Services (PDMS) department at 714-246-8468.
c. The claim submission must be within the timeline guidelines. If the claim is past submission
timeliness, a Provider Dispute Resolution Request (PDR) form must be submitted with the
appropriate documentation indicating why the claim is submitted late. If the claim lines were not
voided or the provider sends a written request, the monies will be re-issued and payment will be
referenced on a future Remittance Advice Detail (RAD).
d. If the check is returned by a provider because of an incorrect payment, the check will be
re-deposited into a suspense account. The incorrect payment is to reduce the provider’s 1099
earnings amount. If there are any correct claims that should be paid to the provider, the provider
must re-bill the claim for reprocessing.

3. Misdirected Remittance Advice Details (RADs) and Checks
   a. CalOptima Direct inserts RADs and checks for the same provider in one envelope. Sometimes
      this may result in mailing a RAD and check to an incorrect provider. If a misdirected check is
      inadvertently cashed, you may forward a check and the RAD to the correct provider. If you
      prefer, you may make your check out to CalOptima Direct and forward with the RAD to:

      CalOptima Direct
      P.O. Box 11037
      Orange, CA 92856

   b. For CalOptima’s OneCare (HMO SNP) or OneCare Connect program, the provider can return
      funds to OneCare by sending a check to OneCare or OneCare Connect along with the
      Remittance Advice Details statement to:

      OneCare (HMO SNP)
      P.O. Box 11065
      Orange, CA 92856

4. Retain Original Remittance Advice Details (RADs)
   a. The CalOptima Direct RADs you receive with each check write are the only record of
      CalOptima Direct claims adjudication you will be sent. Retain original RADs for future
      reference.
This section applies to the following CalOptima programs:

Medi-Cal

**H12: NDC BILLING GUIDELINES FOR CALOPTIMA DIRECT**

This section contains information to help providers bill accurately for physician-administered drugs on the CMS-1500 and UB04 claim form with a National Drug Code (NDC) effective April 1, 2009, per the Department of Health Care Services (DHCS.)

**BILLING TIPS FOR SUBMITTING NDC NUMBERS**

**What is an NDC Number?**

- An NDC number on a drug container consists of digits in a 5-4-2 format. Hyphens (-) separate the number into three segments. Although an NDC on a drug container may have fewer than 11 digits, an 11-digit number must be entered on the claim. An NDC entered on the claim must have five digits in the first segment, four digits in the second segment, and two digits in the last segment. The first five digits of an NDC identify the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The remaining digits are assigned by the manufacturer and identify the specific product and package size. **Placeholder zeros must be entered on the claim wherever digits are needed to complete a segment.**
- Here are examples of entering placeholder zeros on the claim:

<table>
<thead>
<tr>
<th>Package NDC</th>
<th>Zero Fill</th>
<th>11-digit NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234-1234-12</td>
<td>(01234-1234-12)</td>
<td>01234123412</td>
</tr>
<tr>
<td>12345-123-12</td>
<td>(12345-0123-12)</td>
<td>12345012312</td>
</tr>
<tr>
<td>2-22-2</td>
<td>(00002- 0022- 02)</td>
<td>00002002202</td>
</tr>
</tbody>
</table>

**Box 24A: Product Qualifier**

In the shaded area of Box 24A, enter the product ID qualifier N4 and NDC followed by the 11-digit NDC. Omit spaces and hyphens.

**Box 24D: Unit of Measure — Qualifier and Quantity**

In the shaded area of Box 24D, enter the two-character unit of measure qualifier followed by the numeric quantity (a 10-digit number) administered to the patient. The 10 digits consist of seven digits for the whole number, followed by three decimal places. Omit the decimal point when entering the number on the claim. Valid unit of measure qualifiers are as follows:

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Unit of Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2</td>
<td>International Unit</td>
</tr>
<tr>
<td>Qualifier</td>
<td>Unit of Measure</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
</tr>
<tr>
<td>GR</td>
<td>Gram</td>
</tr>
<tr>
<td>ML</td>
<td>Milliliter</td>
</tr>
<tr>
<td>UN</td>
<td>Unit</td>
</tr>
</tbody>
</table>

**Note:** Unit of measure qualifier and numeric quantity are optional. Absence of these two elements will not result in claim denial.

**Note:** All other necessary billing information (dates of service, HCPCS codes, etc.) is entered in the unshaded areas of the form.

**Quantity Reporting**

It is sometimes necessary for providers to bill multiple NDCs for a single drug. For example, when two different strengths of the same drug are needed in order to administer the appropriate dose, or when multiple vials of the same drug are used to administer the appropriate dose and the vials are from different manufacturers. When more than one NDC is needed to bill with one HCPCS code, all NDCs must be included on the claim. The quantity for each NDC must be reported separately by repeating the HCPCS code with its corresponding NDC.

**Section 340B Drugs**

Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier UD in the modifier area (unshaded) of Box 24D. Section 340B drugs may be billed on the same claim as non-340B drugs.
H13: PROVIDER DISPUTE RESOLUTION PROCESS: CALOPTIMA DIRECT AND SHARED RISK CLAIMS

CalOptima offers the Provider Dispute Resolution Request (PDR) process for providers to resolve issues involving claims submitted to CalOptima. **NOTE:** The Provider Dispute Resolution process has replaced the Claims Resubmission process. The Provider Dispute Resolution process is used primarily to address underpayment and overpayment issues. These include:

- Claim was underpaid per Medi-Cal rates or contract terms.
- Claim was overpaid due to a payment or billing error.
- Procedures were denied as inclusive to another procedure in error.
- Corrected claims where a previous payment was made (If a previous payment has not been made, claim should be submitted as an original claim, not as a dispute.)

Please note that this section does not apply to claims submitted to a health network. Providers who want to dispute a health network claim should contact the health network directly.

FILING A PROVIDER DISPUTE RESOLUTION REQUEST FOR CLAIMS ISSUES

1. To submit a Provider Dispute Resolution Request, the provider should complete a Provider Dispute Resolution Request form (PDR). Providers can obtain a copy of the Provider Dispute Resolution Request form on the CalOptima website at [www.caloptima.org](http://www.caloptima.org/).

2. Send Completed Provider Dispute Resolution Request forms to:

   CalOptima  
   Attention: Claims Resolution Unit  
   P.O. Box 11037  
   Orange, CA 92856

3. Provider disputes should be sent within one year of the last determination for timely consideration.

4. CalOptima will send an acknowledgement letter to the provider within 15 working days of receipt.

5. If additional information is required for resolution, a written request will be sent within 15 working days of receipt. The request will indicate specific information needed to complete review of dispute.

6. Provider disputes will be resolved and a resolution letter indicating disposition of the dispute will be sent to the provider within 45 working days of receipt.

The Provider Dispute Resolution process has been put into place at CalOptima to ensure that best practices are used for proper feedback and resolution of claim payment/denial discrepancies.

CalOptima’s Claims Provider Dispute Process should be used prior to filing a Complaint with CalOptima’s Grievance and Appeals department. Claim issues that should be forwarded to the Grievance and Appeals department would include retro authorization requests for denied days or level of care discrepancies that require
medical and or authorization review. For more information on how to file with Grievance and Appeals department, see the **Section R1: Provider Complaint Process**.

### CalOptima Policies and Procedures:

FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group
H13: PROVIDER DISPUTE RESOLUTION PROCESS: ONECARE (HMO SNP) AND ONECARE CONNECT CLAIMS

OneCare (HMO SNP) and OneCare Connect offer the Provider Dispute Resolution process for contracted providers to resolve claim issues. **Non-contracted providers should follow the protocol outlined in Section R1: Provider Complaint Process** of this manual. Furthermore, this guidance only applies to facility claims, since OneCare and OneCare Connect are directly responsible for adjudicating claims for facility services rendered to OneCare and OneCare Connect members. For disputes regarding claims filed with the member’s OneCare or OneCare Connect health network, providers should contact the health network directly.

**FILING A PROVIDER DISPUTE RESOLUTION FOR CLAIM ISSUES**

1. **Completing a Provider Dispute Resolution Form:**
   To dispute a claim processed by the OneCare Connect Claims department, the provider should complete a OneCare Connect Provider Dispute Resolution Request form. To obtain a copy of this form, please visit CalOptima’s website at [www.caloptima.org/](http://www.caloptima.org/).

2. **Submitting the OneCare Connect Provider Dispute Resolution Request to OneCare Connect:**
   Send the completed OneCare Connect Provider Dispute Resolution Request form to:
   
   CalOptima OneCare Connect  
   Claims Provider Dispute  
   P.O. Box 11065  
   Orange, CA 92868

3. **Submitting the OneCare Provider Dispute Resolution Request to OneCare:**
   Please send the completed OneCare Provider Dispute Resolution Request form to:
   
   CalOptima OneCare (HMO SNP)  
   Claims Provider Dispute  
   P.O. Box 11065  
   Orange, CA 92868

4. **Filing Within the Required Time Frame and Next Steps:**
   a. Provider disputes must be submitted to OneCare or OneCare Connect within 365 days of the most recent determination/action for the claim.
   b. OneCare or OneCare Connect will send an acknowledgement letter to the contracted provider within 15 working days of receipt.
   c. If additional information is required for resolution, a written request will be sent within 15 working days of receipt. The request will indicate specific information needed to complete review of dispute.
   d. Provider disputes will be resolved and a resolution letter will be sent to the provider within 30 days of receipt.
5. The Provider Dispute Resolution process has been put into place for OneCare and OneCare Connect to ensure that best practices are used for proper feedback and resolution of payment/denial or contested claim discrepancies.

6. The Provider Dispute Resolution process should be used prior to filing a formal appeal to CalOptima’s Grievance and Appeals department. For more information on how to file a complaint with the Grievance and Appeals department, see Section R1: Provider Complaints Process.
H14: MEMBER BILLING RESTRICTIONS

The Department of Health Care Services (DHCS) and CalOptima have specific guidelines restricting the billing of CalOptima members by providers. This section describes the general prohibition on billing members for covered services, as well as the restrictions governing when a provider may bill a member.

BILLING MEMBERS FOR COVERED SERVICES IS PROHIBITED

The DHCS prohibits providers from charging members for Medi-Cal covered services or having any recourse against the member or the DHCS for Medi-Cal covered services rendered to the member.

1. The prohibition on billing the member includes, but is not limited to:
   a. Covered services
   b. Covered services provided during a period of retroactive eligibility
   c. Covered services once the member meets his or her share of cost requirement
   d. Co-payments, coinsurance, deductible or other cost sharing required under a member’s other health coverage
   e. Pending, contested or disputed claims
   f. Fees for missed, broken, cancelled or same-day appointments
   g. Fees for completing paperwork related to the delivery of care (e.g., immunization cards, WIC forms, disability forms, and forms related to Medi-Cal eligibility.)

2. A provider who accepts a member as a patient must accept payment in full from CalOptima, its health network, medical group or third party administrator for covered services.

LIMITED CIRCUMSTANCES IN WHICH THE MEMBER MAY BE BILLED

A provider may bill a member only for services not covered by Medi-Cal, if:

1. The member agrees to the fees in writing prior to the actual delivery of the non-covered services, and
2. A copy of the written agreement is provided to the member and placed in his or her medical record, or
3. The rendering provider is not registered with Medi-Cal.

FACTS ABOUT THE MEMBER BILLING RESTRICTIONS

1. Providers should always verify a CalOptima member’s eligibility prior to rendering covered services and, if applicable, obtain appropriate prior authorization in accordance with CalOptima Policies and Procedures.

2. With the exception of required co-payments or Medi-Cal share of cost, a participating provider should not bill, seek reimbursement or attempt to collect payment from a CalOptima member or the member’s representative for covered services.

3. With the exception of required co-payments or Medi-Cal share of cost, a non-participating provider should not bill, seek reimbursement or attempt to collect payment from a CalOptima member or the
member’s representative for authorized, urgent or emergent covered services.

4. Providers should not collect payment (check, cash or credit card) for services rendered in lieu of billing a claim to CalOptima, its health network, medical group or third party administrator.

5. Providers should not bill a member for a claim that has been denied due to lack of authorization or due to untimely filing. Providers are solely responsible for seeking authorization of services and for submitting claims timely.

6. Providers should never ask a CalOptima member to inquire about the status of a claim. The provider’s staff cannot involve the member in any of the steps to collect payment from CalOptima.

CalOptima Policies and Procedures:
AA.1220: Member Billing
H14: MEMBER BILLING RESTRICTIONS

This section describes the restrictions on billing members for covered services, as well as the circumstances under which a provider may bill a member.

RESTRICTION ON BILLING MEMBERS FOR COVERED SERVICES

1. Providers contracted with OneCare (HMO SNP) or OneCare Connect health networks cannot bill OneCare or OneCare Connect members for covered services, except for applicable coinsurance or co-payment amounts. Furthermore, providers cannot sue a member to collect sums owed by OneCare or OneCare Connect or its contracted health network.

2. The prohibition on billing of the member includes, but is not limited to:
   a. Covered services (inclusive of both Medicare and Medi-Cal covered services)
   b. Covered services provided during a period of retroactive eligibility
   c. Covered services once the member meets his or her share of cost requirement
   d. Co-payments, coinsurance, deductible or other cost sharing required under a member’s other health coverage
   e. Pending, contested or disputed claims
   f. Fees for missed, broken, cancelled or same-day appointments
   g. Fees for completing paperwork related to the delivery of care (e.g., immunization cards, WIC forms, disability forms, and forms related to Medi-Cal eligibility.)

LIMITED CIRCUMSTANCES IN WHICH THE MEMBER MAY BE BILLED

A provider may bill a member only for non-covered services (not covered by Medicare or Medi-Cal) if:

1. The member agrees to the fees in writing prior to the actual delivery of the non-covered services, and

2. A copy of the written agreement is provided to the member and placed in his or her medical record.

Services may not be covered if they are not included among the Medicare or Medi-Cal benefits available to the member or if the services are not medically necessary.
H15: STERILIZATION CONSENT AND PROCEDURES

INTRODUCTION

Under the regulations, human reproductive sterilization is defined as any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations, which are performed because pregnancy would be life-threatening to the mother (so-called “therapeutic” sterilizations) are included in this definition. The term sterilization, as used in Medi-Cal regulations, means only human reproductive sterilization, as defined above.

Medi-Cal Coverage Conditions for Sterilizations

The conditions under which sterilization procedures for both inpatient and outpatient services are reimbursable by Medi-Cal conform to federal regulations. A sterilization will be covered by Medi-Cal only if the following conditions are met:

- The individual is at least 21 years old at the time written consent for sterilization is obtained.
- The individual is not mentally incompetent. A mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state or local court of competent jurisdiction for any purposes that include the ability to consent to sterilization.
- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure.
- The individual is not institutionalized. For the purposes of Medi-Cal reimbursement for sterilization, an institutionalized individual is a person who is:
  1. Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
  2. Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness
- The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section.

Further Coverage Conditions

At least 30 days, but not more than 180 days have passed between the date of the written and signed informed consent and the date of sterilization, except in the following instances:

- Sterilization may be performed at the time of emergency abdominal surgery if:
  1. The patient consented to the sterilization at least 30 days before the intended date of sterilization, and
  2. At least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.
- Sterilization may be performed at the time of premature delivery if the following requirements are met:
  1. The written informed consent was given at least 30 days before the expected date of delivery, and
  2. At least 72 hours have passed after written informed consent to be sterilized was given.
Sterilization Claims Submissions

A completed consent form must accompany all professional claims for sterilization services. Facility claims are not required to have the PM 330 completed, but the treating provider is required to complete this form. This requirement extends to all providers, attending physicians or surgeons, assistant surgeons, anesthesiologists and facilities. However, only claims directly related to the sterilization surgery require consent documentation. Claims for pre-surgical visits and tests or services related to post-surgical complications do not require consent documentation.

Informed Consent Process

1. The informed consent process may be conducted either by a physician or by the physician’s designee.
2. The physician or the physician’s designee has obtained the informed consent of the individual under the circumstances listed below.

The physician or physician’s designee must:

- Offer to answer any questions the person had regarding the procedure.
- Provide the PM330 form and sterilization booklet published by DHS.
- Inform the individual that they are free to withdraw consent at any time.
- Provide a full description of alternative methods of family planning and birth control.
- Advise the member that the procedure is considered permanent.
- Provide a thorough explanation of the specific procedure to be performed.
- Inform the member of potential risks and post-surgical discomforts, the approximate level of service (LOS), time of recovery, financial cost, and information that the procedure is established or new.
- Advise that the sterilization will not be performed for at least 30 days except under circumstances of premature delivery or emergency abdominal surgery.
- Provide the name of the physician performing the procedure, with the patient being notified of substitutions prior to administering pre-anesthetic medication.
- Make suitable accommodations for patients who are blind, deaf or otherwise handicapped.
- Ensure an interpreter is provided, when necessary.
- Ensure the individual to be sterilized was permitted to have a witness of their choice present when consent was obtained.
- Ensure the sterilization operation was requested without fraud, duress or undue influence.
- Ensure the appropriate consent form was properly signed and completed.

Sterilization Forms

1. The only sterilization form accepted by Medi-Cal is the DHS Consent Form (PM330).
2. Claims submitted with a computer-generated form or any other pre-printed version of the PM330 will not be reimbursed.
3. The Sterilization Consent Form requirements are imposed by the federal government and can be located in the California Code of Regulations, Title 22, Section 51305.4.
4. The instructions for the form must be completed exactly as requested.
5. This form cannot be substituted for the General Consent for Surgery form.

Informed consent may not be obtained if the member is:

- Under the influence of alcohol or other substances that affect the member’s state of awareness
- In labor or within 24 hours postpartum or post-abortion

Section H: Claims and Billing Guidelines
Members Seeking or Obtaining Abortions

1. Seeking to obtain means the period of time during which the abortion decision and the arrangements for the abortion are being made.
2. Obtaining an abortion means the period of time during which a member is undergoing the abortion procedure, including any period during which preoperative medication is administered.

Medi-Cal regulations prohibit sterilization consent being given to a member who is seeking to obtain or obtaining an abortion. However, this does not mean that the two procedures may never be performed at the same time. If the member gives consent to sterilization, and later wishes to obtain an abortion, the procedures may be performed concurrently. An elective abortion does not qualify as emergency abdominal surgery, and the procedure does not affect the 30-day minimum wait.

Ordering Consent Forms

Sterilization Consent Forms can be downloaded from the Medi-Cal website by accessing www.medi-cal.ca.gov, or by calling 800-541-5555. Providers must provide their National Provider Identifier (NPI) number when ordering the forms.

The following information may also be requested:

- Date
- Name of Document (Sterilization Consent Form, PM330)
- Name of Provider/ Facility (Registered provider name associated with NPI)
- Complete Mailing Address (P.O. Box not accepted)
- Quantity of forms requested
- Contact person and telephone number

QUESTIONS ABOUT STERILIZATION CONSENT

For further information regarding sterilization consent and procedures, contact CalOptima’s Claims department at 714-246-8885.
I1: FORMULARY INFORMATION

CalOptima maintains an Approved Drug List (also referred to as a “Formulary”) for the Medi-Cal plan, which lists medications available to CalOptima members without the need for prior authorization. CalOptima also maintains formularies for OneCare and OneCare Connect that list prior authorization requirements, quantity limits and step therapy edits.

The CalOptima Pharmacy and Therapeutics Committee is responsible for development of the CalOptima formularies, which are based on sound clinical evidence. Therapeutic classes in the formulary are reviewed at least annually by the CalOptima Pharmacy and Therapeutics Committee, which consists of actively practicing CalOptima physicians and pharmacists. Quarterly updates to the CalOptima formularies are communicated via our website to both members and providers.

HOW TO ACCESS THE FORMULARY

You can access the CalOptima formularies on our website at www.caloptima.org/.

You may also access the CalOptima formularies by using Epocrates®, which provides free mobile and online access to national and regional health care insurance formularies, including all Medicare Part D formularies. For more information about accessing the Approved Drug List using Epocrates®, please visit their website at www.epocrates.com/.
I2: PHARMACY PRIOR AUTHORIZATIONS

In some instances, CalOptima’s formularies may not include specific medications that a physician may want to prescribe for a member. A physician can submit a prior authorization or exception request for a medication that is not listed on the formulary or that does not meet a step therapy or contingent therapy restriction, quantity limit or duration-of-therapy limit listed on the formulary.

With very few exceptions, all medically necessary FDA-approved drugs are potentially covered under the CalOptima Medi-Cal pharmacy benefit. CalOptima may cover those drugs not listed on the formulary with an approved prior authorization.

HOW TO REQUEST PRIOR AUTHORIZATION

Complete a pharmacy prior authorization request form and fax the completed form to 858-357-2557. For more information on this process and a copy of the form, please visit CalOptima’s website at www.caloptima.org/.

1. You may request a pharmacy prior authorization by phone by calling CalOptima’s pharmacy benefit manager at 888-807-5705 and following the automated instructions.

2. You may request a pharmacy prior authorization online using the Web Submission Form located on CalOptima’s website at www.caloptima.org/.

3. If you submit a pharmacy prior authorization form by fax, be sure to complete the form legibly. Illegible forms may result in processing delays, or CalOptima may return forms that are illegible or incomplete.

4. It is important to include documentation of appropriate clinical information that supports the medical necessity of the requested medication, quantity, refill frequency or duration of therapy. Also, document formulary drugs tried previously, along with the resulting clinical outcome.

5. Include any additional documentation requested by the reviewer to support medical justification (e.g., progress notes, specialty consult evaluations and recommendations, laboratory results, etc.).
I3: MONTHLY MEDICATION LIMIT

CalOptima maintains a monthly prescription limit of six medications per member per calendar month to minimize the risk of polypharmacy, the excessive and potentially dangerous use of prescription drugs and over-the-counter medications. Polypharmacy increases the risk of adverse drug reactions and drug-to-drug interactions.

CalOptima recognizes that some of your patients have unique medication needs. As a result, physicians may prescribe medications in excess of this limit with prior approval from CalOptima. CalOptima will approve requests to exceed this monthly limit if medically necessary. Please note that medications found on the Maintenance Drug List may be dispensed for up to a 60-day or 100-day supply (see individual medications listed). The Maintenance Drug List is posted on CalOptima’s website.

CalOptima has standing exemptions for members with certain conditions or medical needs, including members with HIV/AIDS, transplant patients, cancer patients, patients who reside in nursing or subacute care facilities, and other individuals (on a case-by-case basis).

HOW TO REQUEST AN EXEMPTION TO THE LIMIT

To request an exemption from CalOptima’s monthly medication limit on behalf of a member, complete the Request for Member Exemption from the Monthly Medication Limit form. For more information on the exemption limits and the form, please refer to CalOptima’s website at www.caloptima.org/.

1. Once you have completed the form, fax it to CalOptima at 714-481-4604.

2. Alternatively, you may also request an exemption by sending a letter to:

   CalOptima Pharmacy Management Department
   Attn: Polypharmacy Program
   505 City Parkway West
   Orange, CA 92868
**I4: MEDICATION THERAPY MANAGEMENT PROGRAM**

The OneCare Medication Therapy Management (MTM) program is a requirement under Medicare Part D and was developed with input from practicing pharmacists and physicians. Through a comprehensive review of a member’s drug regimen, the primary goal of the Medication Therapy Management program is to identify, resolve and prevent medication-related problems to achieve optimal outcomes of drug therapy.

On a quarterly basis, CalOptima will identify certain members for participation in the program who will receive medication education materials. Members will be invited to participate in the program if they:

1. Receive medications for three or more of the following diseases: diabetes, asthma, COPD, hypertension, hyperlipidemia or ESRD;

2. Receive more than eight medications per quarter

3. Are projected to exceed the Centers for Medicare & Medicaid Services (CMS)-defined threshold in pharmacy expenditures annually.

**HOW TO FIND OUT MORE ABOUT ONECARE’S MTM PROGRAM**

1. The member’s primary care provider (PCP) plays an important role in the provision and coordination of quality care to OneCare and OneCare Connect members. Providers whose patients qualify for the Medication Therapy Management program will be notified to ensure coordination of the Medication Therapy Management program with respect to care given by the provider.

2. If you have questions about how best to coordinate the member’s care in conjunction with the Medication Therapy Management program, contact the Medication Therapy Management program staff at 714-246-8471.
I5: Medication Use and Treatment Guidelines

This section applies to the following CalOptima programs:

Medi-Cal

I5: MEDICATION USE AND TREATMENT GUIDELINES

To assist its providers most effectively with medications used to manage certain chronic conditions, CalOptima developed medication use guidelines for selected common conditions and for specific injectable drugs. These guidelines provide recommendations on appropriate drug therapy based upon specified clinical indicators, and also provide formulary information and prior authorization criteria. The guidelines were developed in conjunction with physician specialists. For more information on these guidelines, please visit the CalOptima website at www.caloptima.org/.

Clinical Guidelines

- Adult asthma
- COPD
- Diabetes mellitus
- Hyperlipidemia
- Hypertension
- Major depression in adults

Injectable Drug Guidelines

- Colony stimulating factors (CSFs)
- Erythropoietin (Procrit)
- Somatropin (Serostim)
- Palivizumab (Synagis)
- Darbepoetin (Aranesp)

HOW TO ACCESS THE MEDICATION GUIDELINES

For more information on the medication guidelines, please visit CalOptima’s website at www.caloptima.org/.
I6: PHARMACY NETWORK

CalOptima’s pharmacy network includes more than 500 pharmacies in Orange County and surrounding areas. CalOptima maintains a printed directory of network pharmacies, as well as a listing of network pharmacies on its website. Each network pharmacy serves all CalOptima programs — Medi-Cal, OneCare (HMO SNP) and OneCare Connect.

HOW TO LOCATE A CALOPTIMA NETWORK PHARMACY

To find a nearby CalOptima network pharmacy, please visit the Providers section of the CalOptima website.

The website contains three network listings — a list that includes all network pharmacies, a listing of pharmacies providing specialty injectables and a listing of home infusion pharmacies.
J1: COMPLEX CASE MANAGEMENT

Case management is the coordination of care and services for members who have experienced a critical event or diagnosis, or are high-risk members. Typically, these members require extensive use of resources and need help navigating the health care system to facilitate the appropriate delivery of care and services. The goal of CalOptima’s Case Management program is to help members regain health or functional capability.

Who Qualifies for Case Management? Case management is provided to eligible members with specific diagnoses or special health care needs. This includes members with complex, acute and chronic diagnoses, or specialty care management needs. These members typically require extensive use of resources and need assistance in navigating the health care delivery system.

How Does Case Management Benefit Members? Case management provides a consistent method for identifying, addressing and documenting the health care and social needs of our members along the continuum of care. Once a member has been identified for case management, a nurse will work with the member to:

1. Complete a comprehensive initial assessment.
2. Determine benefits and resources available to the member.
3. Develop and implement an individualized care plan in partnership with the member, his or her provider, and family or caregiver.
4. Identify barriers to care.
5. Monitor and follow up on progress toward care plan goals.

HOW TO MAKE A REFERRAL TO CASE MANAGEMENT

1. CalOptima Direct (COD) and CalOptima Community Network (CCN) Members: If a provider identifies a CalOptima member needing case management, the provider can make a direct referral to CalOptima’s Case Management department by calling 714-246-8686, faxing 714-571-2455 or emailing cmtriage@caloptima.org.

2. CalOptima Members Assigned to a CalOptima Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or Shared Risk Medical Group Health Network: If a provider identifies an HMO, PHC or Shared Risk Medical Group member needing case management, the provider can make a direct referral by contacting the member’s assigned health network. For health network contact information, see Section B1: CalOptima Department and Program Contact Information.

If a provider has questions about CalOptima’s Case Management program, call CalOptima’s Case Management department at 714-246-8686.

CalOptima Policies and Procedures:
- GG.1301: Case Management Process
J2: CASE MANAGEMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

CalOptima is required to implement and maintain services for children with special health care needs. These services include, but are not limited to:

1. Ensuring and monitoring timely access to services
2. Providing a comprehensive assessment of the health and related needs of children with special health care needs
3. Case management services with other entities that also serve these children
4. Monitoring and improving the quality and appropriateness of care to children with special health care needs

Who are Children with Special Health Care Needs?

Children with special health care needs are those who:

1. Have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition
2. May have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities or congenital abnormalities
3. Require health and related services of a type or amount beyond that required by children generally

Goals of Children with Special Health Care Need Case Management

The purpose of children with special health care needs case management is to:

1. Coordinate with family and providers to develop an individualized care plan.
2. Facilitate member access to needed services and resources.
3. Prevent duplication of services.
4. Optimize the member’s physical and emotional health and well-being.
5. Improve the member’s quality of life.
6. Provide transition planning.

Emphasis on Coordination

With proper identification of children with special health care needs, along with health risk assessment and development of an individualized care plan, CalOptima’s case managers can refer children to the appropriate
service providers within the community. These service providers include California Children’s Services (CCS), the Regional Center, Early Start, local education agency programs and the child welfare agency.

**TIPS FOR SERVING CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

1. To support CalOptima’s ability to case manage children with special health care needs, primary care providers should perform an initial health assessment within 120 days of enrollment for each new member under age 21. CalOptima uses the initial health assessment data to identify children with special health care needs.

2. If a provider identifies a child with special health care needs and believes he or she would benefit from case management, the provider should contact the CalOptima Care Coordination department at 714-246-8686.

**HOW TO MAKE A REFERRAL**

**CalOptima Direct (COD) and CalOptima Community Network (CCN) Members:** If a provider identifies a CalOptima COD or CCN member with special health care needs, the provider can make a direct referral to CalOptima’s Care Coordination department by calling 714-246-8686, faxing to 714-571-2455, or emailing to cmtriage@caloptima.org

**CalOptima Members Assigned to a CalOptima Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or Shared Risk Medical Group Health Network:** If a provider identifies a CalOptima HMO, PHC or Shared Risk Medical Group member with special health care needs, the provider can make a direct referral by contacting the member’s assigned health network. For health network contact information, see **Section B1: CalOptima Department and Program Contact Information.**
This section applies to the following CalOptima programs:

Medi-Cal

**J3: END-STAGE RENAL DISEASE (ESRD) CASE MANAGEMENT**

CalOptima centrally case manages members over the age of 21 with end-stage renal disease (ESRD) on dialysis. This function is not delegated to any CalOptima health network (health maintenance organization (HMO), physician hospital consortium (PHC) or shared risk medical group), with the sole exception of Kaiser Foundation Health Plan.

**ESRD Patients Managed by CalOptima Community Network** — Because members with ESRD have unique and specialized health care needs, members with ESRD are transferred from their health network into CalOptima Community Network.

**HOW TO REFER MEMBERS WITH END-STAGE RENAL DISEASE**

1. If a provider identifies a member who has end-stage renal disease, and the member is enrolled in a CalOptima health network, the provider should complete the Centers for Medicare & Medicaid Services (CMS) End-Stage Renal Disease Medical Evidence Report and send the completed form to the member’s health network. For CalOptima health network contact information, see Section B1: CalOptima Department and Program Contact Information.

2. The member’s health network will work with CalOptima’s Care Coordination department to transition the member to CalOptima Community Network.

3. If a provider identifies a CalOptima Direct or CCN member with newly diagnosed ESRD, the provider should contact CalOptima’s Care Coordination Department at 714-246-8686, fax to 714-571-2455 or email to cmtriage@caloptima.org.
This section applies to the following CalOptima programs:

Medi-Cal

**J4: HEMOPHILIA CASE MANAGEMENT**

CalOptima centrally case manages members over the age of 21 with hemophilia. This function is not delegated to any CalOptima health network (Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or Shared Risk Medical Group), with the sole exception of Kaiser Foundation Health Plan.

**Hemophilia Patients Managed by CalOptima Community Network** — Because members with hemophilia have unique and specialized health care needs, members with hemophilia are transferred from their health network into CalOptima Community Network.

**HOW TO REFER MEMBERS WITH HEMOPHILIA**

1. If a provider identifies a member who has hemophilia and the member is enrolled in a CalOptima health network, the provider should contact the member’s health network immediately. For health network contact information, see Section B1: CalOptima Department and Program Information. The member’s health network will work with CalOptima’s Case Management department to transition the member to CalOptima Community Network.

2. If a provider identifies a new member with hemophilia who is in CalOptima Direct or CalOptima Community Network, the provider should contact CalOptima’s Case Management department at 714-246-8686, fax to 714-571-2455 or email to cmtriage@caloptima.org.

**CalOptima Policies and Procedures:**

GG.1318: Coordination of Care for Hemophilia Members
This section applies to the following CalOptima programs:

Medi-Cal

J5: TRANSPLANT CASE MANAGEMENT

CalOptima centrally case manages potential transplant patients over the age of 21. This function is not delegated to any CalOptima health network (Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or shared risk medical group), with the sole exception of Kaiser Foundation Health Plan.

CalOptima’s Transplant Program — CalOptima’s transplant case management program provides the resources and education needed to proactively manage members identified as potential transplant candidates. A CalOptima case manager works in conjunction with contracted providers and the Department of Health Care Services (DHCS) Certified Center to assist members through the transplant review process. CalOptima’s case managers monitor patients on an inpatient and outpatient basis, assisting the member, his or her physician and facility in accessing the appropriate level of care in a timely, efficient and coordinated manner.

Who Qualifies for Transplant Coverage — Transplants are covered under Medi-Cal if:

1. The transplant is performed at a DHCS-approved transplant center.

2. The member meets patient selection criteria for the following transplants:
   a. Heart
   b. Heart/lung
   c. Lung
   d. Kidney
   e. Pancreas
   f. Liver/kidney
   g. Bone marrow
   h. Liver
   i. Small bowel
   j. Liver/small bowel
   k. Kidney/small bowel
   l. Kidney/pancreas

Transplant Patients Managed by CalOptima Community Network — Because members requiring organ transplants have unique and specialized health care needs, members who are identified as potential transplant patients are transferred from their health network into CalOptima Community Network.

HOW TO REFER MEMBERS NEEDING A TRANSPLANT

If a provider identifies a member who may need a transplant, and the member is enrolled in a CalOptima HMO, PHC, or shared risk medical group health network, the provider should contact the member’s health network immediately. For a list of CalOptima’s health networks, see Section B1: CalOptima Department and Program Contact Information.

1. The member’s health network will work with CalOptima’s Case Management department to transition the member to CalOptima Community Network and to identify an appropriate transplant center.
2. If a provider identifies a member who may need a transplant and who is enrolled in CalOptima Direct or CalOptima Community Network, the provider should contact CalOptima’s Case Management department at 714-246-8686, fax to 714-571-2455 or email to cmtriage@caloptima.org.

CalOptima Policies and Procedures:
GG.1105: Coverage of Organ and Tissue Transplants
GG.1313: Coordination of Care for Transplant Members
J6: Referring Members for Case Management

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

**J6: REFERRING MEMBERS FOR CASE MANAGEMENT**

Case management is the coordination of care and services for members who have experienced a critical event or diagnosis, or are high-risk members. Typically, these members require extensive use of resources and need help navigating the health care system to facilitate the appropriate delivery of care and services.

OneCare (HMO SNP)’s contracted health networks are responsible for providing case management services for OneCare members. OneCare’s health networks perform a comprehensive assessment of the member’s condition, determine the available benefits and resources, develop and implement a case management plan, and monitor and follow up with the member.

OneCare (HMO SNP)’s health networks provide case management for both members with high-risk potential, as well as members with catastrophic illnesses/conditions.

**High-Risk Criteria** — Members with high-risk profiles exhibit one or more of the following criteria:

1. Active chronic diagnoses
2. Two or more hospitalizations in the past three months
3. Two or more emergency room visits in the past three months
4. Experiences a transition in care or change in health status
5. Has significant impairment in one or more activities of daily living (e.g., bathing, dressing, toileting or ambulating)
6. Has significant impairment in one or more of the instrumental activities of daily living (e.g., preparing meals, shopping, housekeeping, transportation, using the telephone or managing finances), particularly when no support system is present
7. Developmentally delayed member
8. Has evidence of malnutrition

**Catastrophic Condition Criteria** — A member may also qualify for case management due to a catastrophic illness or condition. Catastrophic illnesses include, but are not limited to:

1. Extensive burns (i.e., 30 percent or greater of body surface area)
2. Traumatic brain injuries
3. Multiple traumatic injuries
4. Organ transplant
5. Oncology patients not on hospice
6. Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)
7. Chronic major psychiatric illness
8. Guillain-Barre
9. Amytropic lateral sclerosis or other neuro-degenerative disease

Upon review of a member’s prescription drug medications, OneCare (HMO SNP) or its contracted health networks may also include members who meet any of the following criteria for case management follow up:

1. Members taking eight or more medications
2. Members hospitalized for adverse medication reaction
3. Members who have multiple prescribing physicians
4. Prescription drug cost outliers

OneCare or its contracted health networks may consider members whose length of stay or cost incurred is above the standards established by nationally accepted standards or cost outliers as an indication for case management:

1. Members among the top three percent of utilization
2. Members who have annual ambulatory costs of $10,000 or more, excluding one-time durable medical equipment (DME)
3. Members who have an annual inpatient cost of $50,000 or more

HOW TO REFER A MEMBER FOR CASE MANAGEMENT SERVICES

If a provider identifies a member who would benefit from case management services, the provider should immediately contact the member’s OneCare (HMO SNP) health network. For OneCare (HMO SNP) health network contact information, see Section B1: CalOptima Department and Program Contact Information.
J7: MODEL OF CARE

OVERVIEW
The Centers for Medicare & Medicaid Services (CMS) require all Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC). The SNP Model of Care is CalOptima’s road map for care management policies, procedures and operational systems. There are four core elements of the OneCare Model of Care including:

- Description of the overall Special Needs Plan (SNP) population
- Care coordination
- Provider network
- Quality measurement and performance improvement

DESCRIPTION OF THE ONECARE POPULATION
The OneCare population is described by the following:

- Eligibility to participate in OneCare
- Social, cognitive, environmental factors, living conditions and co-morbid conditions of OneCare members
- Medical and health conditions impacting OneCare members
- Unique characteristics of the OneCare population
- Identification of the most vulnerable members of OneCare with specialized services listed for these members

Description of OneCare Population: Most Vulnerable Members
OneCare has identified the following special populations:

- Frail/disabled members
- Members in need of disease management
  - Diabetes mellitus (DM)
  - Congestive heart failure (CHF)
- Members with behavioral health needs
- Institutionalized members
- Members at end of life

CARE COORDINATION
Care coordination is defined as the following:

- **OneCare Staff Structure** — Administrative, clinical and oversight roles specific to OneCare including personal care coordinators (PCC)
- **Health Risk Assessment** — Assessment of the OneCare member’s health needs
- **Individualized Care Plan (ICP)** — A plan of care for the OneCare member based on information from the Health Risk Assessment
• **Interdisciplinary Care Team (ICT)** — A team of medical, behavioral and ancillary providers, plus the OneCare member and an authorized representative. The ICT convenes to manage the member’s care and assure care coordination.

• **Care Transition Protocols** — Guidelines on how to manage the OneCare member across the care continuum

**Care Coordination: Staff Structure and Roles**

OneCare staff is organized to align with essential care management roles:

- Administrative staff
- PCC staff
- Clinical staff
- Oversight staff

**Care Coordination: Administrative Roles**

OneCare administrative roles manage:

- Enrollment
- Eligibility
- Claims
- Grievances and provider complaints
- Information communication
- Collection, analysis and reporting of performance and health outcomes data

**Care Coordination: Role of the PCC**

The PCP at a health network or CalOptima is someone who helps members navigate the health care system and obtain the most optimal health care services, ensuring the best possible health care outcomes for all CalOptima members.

PCCs:

- Are the single point of contact for OneCare members
- Participate in ICT meetings to finalize member’s ICP
- Review member’s ICP goals
- Develop an outreach schedule for member care plan goals and needs
- Are the liaison between the member, provider, health network and CalOptima

The CalOptima PCC:

- Administers the telephonic HRA
- Inputs HRA responses into a data platform for RN review
- Communicates PCC key event triggers and conducts warm transfers with the health network

**Care Coordination: Clinical Roles**

OneCare clinical roles:

- Advocate for, inform and educate members
- Identify and facilitate access to community resources
- Coordinate care
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their health care
- Maintain and share records and reports
- Assure Health Insurance Portability and Accountability Act (HIPAA) compliance

**Care Coordination: Oversight Roles**

OneCare Oversight Roles:

- Monitor Model of Care implementation
- Evaluate effectiveness of Model of Care
- Assure licensure and competency
- Assure statutory and regulatory compliance
- Monitor contractual and delegated services
- Monitor interdisciplinary care teams
- Assure timely and appropriate delivery of services
- Assure providers use evidence-based clinical practice guidelines
- Assure seamless transitions and timely follow up

**Care Coordination: Health Risk Assessment**

OneCare Health Risk Assessment (HRA):

- CalOptima OneCare PCC administers initial (90-day) and an annual HRA for each member. The HRA is not delegated to the health networks.
- OneCare uses a standardized HRA tool.
- HRA is used to evaluate the medical, psychosocial, cognitive, and functional needs with medical and behavioral health history.
- Results are used to develop the member’s individualized care plan (ICP).
- HRA may be face-to-face, telephonic, electronic or paper-based.
- HRA identifies care needs that are categorized into care domains: Access, Coordination of Services, Health Monitoring, Medical-Acute, Medical-Chronic, Behavioral Health, Long-Term Care, and Long-Term Support Services (LTSS).

**Care Coordination: Individualized Care Plan (ICP) Roles**

OneCare ICP roles:

- An interdisciplinary care team develops the ICP for each OneCare member.
- Members or caregivers (at the member’s request) are involved and are asked to sign off on the ICP.
- The ICP is reviewed and revised annually or when health status changes.
- An ICP includes personalized goals and objectives, specific services and benefits, and measurable outcomes.
- The ICP goals and objectives are prioritized by member preference.
- The ICP is communicated to members, caregivers and providers.
- Records are per HIPAA and professional standards.
- The ICP must be signed by the PCP.
- The ICP must be shared with appropriate specialty providers.

**Care Coordination: Interdisciplinary Care Team (ICT)**

OneCare ICT Roles:
Analyze and incorporate the results of the initial and annual HRA in the ICP, utilizing evidence-based guidelines.

Collaborate to develop and annually update the member’s ICP.

Manage the medical, cognitive, psychosocial and functional needs of each member.

Communicate the ICP to all caregivers for care coordination.

Provide a copy of the ICP to the member in the member’s preferred language, font and print size.

The ICT must include:

- Member
- PCP assigned to the member
- PCC

The ICT may also include:

- Behavioral health specialist
- Pharmacist
- Case manager
- Therapist (speech, physical)
- Nutritionist
- Appropriate specialist
- Pastoral specialist
- Health educator
- Disease management specialist
- Social worker

**PROVIDER NETWORK**

Provider network includes:

- Specialized expertise such as:
  - a. Specialists
  - b. Hospitalists
  - c. Skilled nursing facility providers
  - d. Behavioral health providers
  - e. Pharmacists
  - f. Crisis teams
  - g. Allied health providers
  - h. Ancillary services
  - i. Substance abuse detoxification and rehabilitation services

- Use of evidence-based clinical guidelines and care transition protocols:
  - a. Formalize oversight of provider network adherence to nationally recognized care standards

- OneCare Model of care training for the provider network:
  - a. Assure provision and attestation of initial and annual MOC training

**OneCare Provider Network**

OneCare Provider Network includes:

- Contracting with board-certified providers
Monitoring network providers to assure they use nationally recognized clinical practice guidelines
- Assuring that network providers are licensed and competent through a formal credentialing review
- Having a broad network of specialists including palliative care, pain management, chiropractors and psychiatrists
- Monitoring network adequacy to ensure access to care

**OneCare Specialty Provider Network Programs**

OneCare specialty provider network programs include:
- OneCare behavioral health program
- Specialty service programs including dialysis, transportation, durable medical equipment (DME) and home health
- Psychosocial programs such as homelessness and recuperative programs
- Specialty referral program that refers members to Community-Based Adult Services (CBAS), In-Home Supportive Services, housing assistance, Meals on Wheels and personal finance counseling
- Disease management and health education programs
- Community-based support programs such as Aging and Disability Resource Center (ADRC), Multipurpose Senior Services Program (MSSP), Office on Aging (OOA), and Dayle MacIntosh Center (independent living)

**QUALITY MEASUREMENT (QM) AND PERFORMANCE IMPROVEMENT (PI)**

Quality measurement (QM) and performance improvement (PI) are evaluated by:
- Model of Care (MOC) Quality Performance Improvement Plan
- Measurable goals and health outcomes measurements for the MOC
- Measuring member experience of care
- Ongoing performance improvement evaluation
- Dissemination of SNP quality performance related to the MOC

**Performance Measurement**

OneCare uses standardized quality improvement measures performance and health outcomes such as:
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Disease management measures
- Utilization management measures
- Member satisfaction (surveys)
- Provider satisfaction (surveys)
- Ongoing monitoring of complaints and grievance summaries
- Tracking and assessing completion of MOC training

**OneCare MOC Measurable Goals**

OneCare evaluates measurable goals that:
- Improve access to medical, behavioral and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Improve access to preventive health services.
- Assure appropriate utilization of services.
- Assure cost-effective service delivery.
- Improve member health outcomes.

**Measurement of Effectiveness**

OneCare measures MOC effectiveness by collecting and reporting data on:

- Improvement in access to care
- Improvement in member health status
- Staff implementation of MOC
- Comprehensive HRA
- Implementation of ICP
- Provider network of specialized expertise
- Application of evidence-based practice
- Improvement of member satisfaction and retention

**OneCare Clinical Guidelines**

OneCare supports the physician management of chronic conditions by dissemination of best practices, evidence-based guidelines, and provider tool kits to promote education and adherence.

**Summary**

OneCare’s Model of Care (MOC) creates a comprehensive strategy and infrastructure to meet the unique needs of the dual-eligible population by:

- Setting agencywide strategic goals
- Contracting with expert providers
- Striving to meet each member’s unique medical, psychosocial, functional and cognitive needs
J8: CONTINUITY OF CARE

OVERVIEW

CalOptima is required to provide continuity of care as set forth in a Memorandum of Understanding (MOU) by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

CALOPTIMA CONTINUITY OF CARE REQUIREMENTS

In order to meet continuity of care requirements, CalOptima must:

- Ensure members have access to medically necessary items and services, as well as medical and long-term services and support (LTSS) providers.
- Follow continuity of care requirements established in current law.
- Ask the member if there are upcoming appointments and treatments scheduled, and assist the member to initiate the continuity of care process at that time if the member wishes to do so.
  a. Allow a member to continue receiving continuity of care services from out-of-network providers for primary and specialty care services and maintain his or her current providers and service authorizations at the time of enrollment for a period of up to 12 months if the criteria are met.

For clients of the Regional Center of Orange County who are receiving Behavioral Health Treatment (BHT) on July 1, 2018, CalOptima shall initiate continuity of care requests for those members seeing out-of-network providers and who

  a. Have an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the Regional Center (RC) to the Managed Care Plan (MCP) or the date of the member’s initial enrollment in the MCP if enrollment occurred on or after July 1, 2018.
  b. Can agree to a rate between the provider and the MCP, with the minimum rate offered by the MCP being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
  c. Does not have any documented quality of care concerns that would cause him/her to be excluded from the MCP’s network.
  d. Is a California State Plan approved provider.
  e. Provides the MCP relevant documents, including but not limited to, assessments and treatment plans to facilitate continuity of care.

Upon request by the member, CalOptima must offer continuity of care with an out-of-network provider to all OneCare Connect members if the following circumstances exist:

- The member has an existing relationship with a primary care provider (PCP) or specialist provider. An existing relationship means the member has seen an out-of-network provider at least once during the 12 months prior to the date of the member’s initial enrollment in OneCare Connect.
- The provider is willing to accept payment from CalOptima based on the current Medicare or Medi-Cal fee schedule, as applicable.
- CalOptima does not have any quality of care concerns that would cause it to exclude the provider from its network.
If a member opts out of OneCare Connect and later reenrolls, the continuity of care period does not start over. CalOptima is not required to provide continuity of care with an out-of-network provider if any of the following circumstances exist:

- Services not covered by Medi-Cal or Medicare
- The following providers are not eligible for continuity of care: providers of durable medical equipment (DME), transportation, other ancillary services or carved-out services.
- If the provider does not agree to abide by CalOptima’s utilization management policies

**Provider Referral for Out-of-Network Providers**

An approved out-of-network provider must work with CalOptima and cannot refer the member to another out-of-network provider without authorization from CalOptima. In such cases, CalOptima will make the referral, if medically necessary, and if CalOptima does not have an appropriate provider within its network.

**DME, Transportation and Other Ancillary Services**

For DME, transportation and other ancillary services, CalOptima must provide continuity of care for services but is not obligated to use out-of-network providers that are determined to have a pre-existing relationship, for the applicable six or 12 months.

**Continuity of Care for Long-Term Care Facilities**

OneCare Connect members residing in a nursing facility prior to enrollment will not be required to relocate into a network nursing facility if the nursing facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the nursing facility and CalOptima agree to Medi-Cal and/or Medicare rates.

**Additional Continuity of Care Provisions**

CalOptima must also allow OneCare Connect members to have continued use of any (single-source) drugs that are part of prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by CalOptima, until the prescribed therapy is no longer prescribed by the contracted physician.

Additional requirements pertaining to continuity of care require CalOptima, at the request of the member, to provide for the completion of covered services by a terminated or non-participating CalOptima provider. CalOptima is required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as part of a documented course of treatment. CalOptima must allow for the completion of these services for certain time frames, which are specific to each condition.

**CalOptima Policies and Procedures:**

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<th>Policy</th>
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<tr>
<td>CMC.6021a: Continuity of Care for New Members</td>
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<tr>
<td>GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care</td>
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<tr>
<td>MA.6021 Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners</td>
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<td>MA.6021a: Continuity of Care for New Members</td>
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K1: CHILD PROTECTIVE SERVICES

CalOptima providers are required to report reasonable suspected or observed instances of child abuse or neglect within 36 hours of receiving the information concerning the event. These may include cases involving a pregnant minor.

Providers should report suspected or observed instances of child abuse or neglect to the Orange County Child Abuse Registry. By contacting the Child Abuse Registry, providers may be able to do the following:

1. Save a child’s life.
2. Prevent further abuse or neglect.
3. Allow families to receive resources or services, which they may desperately need.
4. Make a valuable contribution to the protection of children and the prevention of abuse.

WHAT IS CONSIDERED CHILD ABUSE?

The law requires certain professionals to report suspicion and/or knowledge of child abuse including, but not limited to:

1. Physical abuse
2. Sexual abuse
3. Neglect
4. Cases of severe emotional abuse that constitute willful or unjustifiable punishment of a child

HOW TO REFER A PATIENT TO CHILD PROTECTIVE SERVICES

1. To report a case of suspected child abuse or neglect, call Orange County Child Protective Services at 714-940-1000 or 800-207-4464, 24 hours a day, seven days a week.

2. If the case is urgent, immediately report the suspected child abuse or neglect to the local law enforcement agency and to Orange County Child Protective Services using the 24-hour hot line noted above.

3. Child abuse reports and information given to child protective services agencies are always confidential by law.

CalOptima Policies and Procedures:
GG.1706: Child Abuse Reporting
K2: LOCAL EDUCATION AGENCY SERVICES

Local education agencies (LEAs) provide certain medically necessary preventive, diagnostic, therapeutic and rehabilitative services to children ages 3 years and older with special health care needs. A child may receive services from his or her local education agency in accordance with the child’s Individualized Education Plan or Individual Family Service Plan.

What Services are Provided by a Local Education Agency? Local education agencies’ educational support services may include the following when identified on the child’s Individualized Education Plan or Individual Family Service Plan:

1. Health and mental health evaluations and education (assessments)
2. Nutritional assessment and education
3. Developmental assessment
4. Vision assessment
5. Psychosocial assessment
6. Psychological and counseling services
7. Physical therapy
8. Occupational therapy
9. Speech therapy
10. Audiology services
11. Nursing services
12. School health aid services
13. Medical transportation and mileage
14. Targeted case management services

Neither CalOptima nor its health networks are responsible for the provision or payment of local education agencies’ services. However, CalOptima is responsible for providing a primary care provider and all medically necessary covered services for the member and shall ensure that the member’s primary care provider cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. CalOptima shall provide case management and care coordination to the member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with primary care provider participation.
IMPORTANT REMINDERS FOR PCPS ABOUT COORDINATING WITH LOCAL EDUCATION AGENCIES

1. PCPs have an opportunity to identify CalOptima members who may be eligible for local education agency services during pediatric preventive screenings, developmental screenings and case management referrals.

2. PCPs should refer members to their local education agency.

3. PCPs need to be involved in the development of the child’s Individualized Education Plan or Individual Family Service Plan.

4. The PCP needs to coordinate local education agency services for the child and needs to be aware of the local education agency services that the child may be receiving.

5. For more information about local education agencies services, please contact the Case Management department at 714-246-8686.

CalOptima Policies and Procedures:
GG.1321: Coordination of Care for Local Education Agency Services
K3: Tuberculosis Directly Observed Therapy Services

This section applies to the following CalOptima programs:

**Medi-Cal**

### K3: TUBERCULOSIS DIRECTLY OBSERVED THERAPY SERVICES

Providers are responsible for furnishing tuberculosis (TB) services to CalOptima members, including TB screening, diagnosis, treatment of latent TB, case management and follow-up care. These services should be provided in accordance with the most recent guidelines from the American Thoracic Society and the Centers for Disease Control and Prevention (CDC).

The Orange County Health Care Agency’s Pulmonary Disease Service (HCA/PDS) monitors TB cases in Orange County and uses Directly Observed Therapy to treat patients at risk of non-compliance for the treatment of TB.

Providers are required to report known or suspected cases of TB, as well as patients at risk of non-compliance for TB treatment, to the HCA/PDS.

### ABOUT PULMONARY DISEASE SERVICES (TUBERCULOSIS CONTROL)

HCA Orange County TB Control offers evaluation and treatment of individuals with active or suspected active TB.

Orange County TB Control offers TB screening services (tuberculin skin testing, chest X-rays, symptom check and physician evaluation, when appropriate) to residents of Orange County who meet the following criteria:

1. Persons with two or more TB symptoms, such as cough, coughing up blood, fever, night sweats, unexplained weight loss

2. Persons with abnormal chest X-rays consistent with active TB disease

3. Persons in contact with an active TB disease case

4. Persons with documentation of a TB test that has gone from negative to positive within the last two years

5. Newly arriving refugees

6. Newly arriving immigrants required by the Centers for Disease Control and Prevention (CDC) / Division of Global Migration and Quarantine (DGMQ) to be evaluated for TB

7. Persons with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)

8. Clients of residential detoxification centers, and drug and alcohol treatment centers

9. Clients of shelters

10. Foreign-born persons resident in the United States less than two years
WHAT TO DO IF YOU IDENTIFY A PATIENT WITH TB

1. If you identify a member with a known or suspected case of TB, report the case to the HCA/PDS office within one working day of identification. Please note that you are still responsible for treating and managing the member’s TB.

2. If you identify a member who is at risk of non-compliance for the treatment of TB, report the case to HCA/PDS TB control office for Directly Observed Therapy and CalOptima or the member’s health network.

3. To report the case to the member’s health network, see Section B1: CalOptima Department and Program Contact Information for a list of health network contact information. To report the case to CalOptima, call the CalOptima Case Management department at 714-246-8686.

4. TB screening and treatment services are offered to eligible Orange County residents at:

   County of Orange Health Care Agency
   Tuberculosis Treatment and Prevention Services Clinic
   1725 W. 17th, Suite 101E
   Santa Ana, CA 92706
   714-834-8717

5. For further information regarding Tuberculosis Directly Observed Therapy Services, please visit the website for the Orange County Health Care Agency at www.ochealthinfo.com.

CalOptima Policies and Procedures:
GG.1128: Tuberculosis Services
K4: WOMEN, INFANTS AND CHILDREN (WIC) SERVICES

Low-income women and young children are eligible for services from the Supplemental Nutrition Program for Women, Infants and Children (WIC), a food and nutrition education program. WIC can reinforce and expand on the primary care provider’s (PCP’s) nutrition recommendations to help keep members at lower risk for health complications.

What Do WIC Services Include?

1. Individual/group counseling on nutrition/health education
2. Supplemental foods supporting nutrition education
3. Support and assistance with breastfeeding
4. Referrals to local agencies and community groups

Who Is Eligible for WIC Services? The following people residing in Orange County may be eligible for WIC services:

1. Women who are pregnant, postpartum and breastfeeding
2. Infants (children under 1 year of age)
3. Children up to 5 years of age (including foster children)
4. Families with low to medium income (working families may qualify)

Participants must be Medi-Cal eligible or meet WIC income eligibility levels.

Neither CalOptima nor its health networks are responsible for the provision or payment of WIC services. However, as part of the referral process, providers shall document the hemoglobin or hematocrit laboratory values and the referral in the member’s medical record. Primary care providers, as part of their initial health assessment of members or, as part of the initial evaluation of pregnant members, shall refer and document the referral of pregnant, breastfeeding or postpartum members or a parent/guardian of a child under the age of five to the WIC program as mandated by Title 42 CFR 431.635(c).

HOW TO REFER A PATIENT TO WIC

1. To make a referral to WIC, you may submit the referral to the WIC Office using any of the following documents:
   a. Child Health and Disability Prevention (CHDP) Program billing form (PM160)
      WIC referral form (to download a WIC referral form, please visit WIC Referral Form)
   b. Prescription pad
2. Referrals should include the member’s name, date of birth, height, weight, estimated date of confinement (EDC) if pregnant, hemoglobin or hematocrit results (if member is over 6 month old) and...
documentation of any nutrition-related risk factors.

3. Instruct the patient to call a WIC agency for an appointment at 888-WIC-WORKS or 888-942-9675.

For more information, patients and health professionals may call WIC at 888-942-2229 or go online at www.cdph.ca.gov

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<th>CalOptima Policies and Procedures:</th>
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<td>GG.1703: WIC Referrals</td>
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K5: COORDINATION WITH COMMUNITY RESOURCES AND SOCIAL SERVICES

To help providers, especially primary care providers, furnish patient-centered care, OneCare Connect, OneCare (HMO SNP) and its contracted health networks have the capability to refer members to local resources providing social and community services. In the course of serving OneCare Connect, and OneCare members, providers may identify specific family, home environment, nutritional or other social needs that affect the member’s health status. Many of these social service needs can be addressed with services that are available from community and social service agencies in Orange County.

OneCare Connect, OneCare and its contracted health networks are responsible for referring members to community and social service programs. These programs include, but are not limited to:

1. Programs that provide nutritional assistance or deliver meals to the home (e.g., Meals on Wheels)
2. Multipurpose Senior Services Program, which helps frail elderly members remain in their homes and avoid unnecessary institutionalization. For more information on the Multipurpose Senior Services Program, see Section C5: Multipurpose Senior Services Program (MSSP).
3. In-Home Supportive Services, which provides in-home care so that elderly and disabled members can remain in their homes
4. Housing assistance, through agencies such as the Orange County Housing and Community Development Department
5. Adult Protective Services, which assists adults at risk for abuse
6. Legal Aid, which provides legal services to seniors, disabled people and other vulnerable individuals
7. Alzheimer’s Association, which provides a 24/7 helpline, support groups and other resources for individuals with Alzheimer’s and their families and caregivers

OTHER COMMUNITY RESOURCES

Along with the resources listed above for members enrolled in OneCare Connect and OneCare, all CalOptima members can access the Members section of the CalOptima website for information regarding other resources available to them. Listed below are two important examples of community resources available to members.

The Aging & Disability Resource Connection of Orange County (ADRCOC) is a collaborative effort led by CalOptima, the Orange County Office on Aging, and the Dayle McIntosh Disability Resource Center designed to streamline access to long-term care by developing “one-stop shop” centers in local communities that help older adults and individuals with disabilities make informed decisions about service and support options available to them.
ADRCOC programs provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients, and individuals planning for their future long-term care needs. ADRCOC programs work toward the goal of serving all individuals with long-term care needs, regardless of their age or disability.

Members may access services through walk-in at the Office on Aging telephonically or via the interactive website.

For more information about ADRCOC, providers and members can visit their website at [www.adrcoc.org](http://www.adrcoc.org/) or call 800-510-2020, or 714-567-7500. Members can use the multi-lingual site to search by category, keyword, name, area served or location to find information for services such as:

1. Adult day health care
2. Disability services and products
3. Emergency hotlines
4. Financial assistance
5. Housing/shelter
6. Meals/food
7. Senior and community centers
8. Support groups
9. Transportation services
10. Veteran’s services

**2-1-1 Orange County** is a comprehensive information and referral system that provides a resource database of health and human services and support, 24 hours a day, 7 days a week online and through their multi-lingual hotline. The website can be accessed at [www.211oc.org](http://www.211oc.org/). By dialing 2-1-1, members may receive assistance for resources such as:

1. Food
2. Housing and utilities
3. 24-hour crisis and suicide counseling
4. Physical and mental health services
5. Elder services
6. Youth and child care issues
7. Substance abuse
8. Transportation

9. Shelter and government assistance programs

HOW TO COORDINATE WITH COMMUNITY RESOURCES

If a provider identifies a member who has specific family, home environment, nutritional or other social needs, the provider should contact CalOptima or the member’s health network. The member’s OneCare health network is responsible for evaluating the member and referring the member to the appropriate community and or social service resources.

For information on how to contact the member’s OneCare health network, see Section B1: CalOptima Department and Program Contact Information of this manual.

For additional information regarding available community resources, visit CalOptima’s website at www.caloptima.org/ or the County of Orange’s Office on Aging website at Orange County Office on Aging.

CalOptima Policies and Procedures:
MA.6019: Coordination of Social Services
This section applies to the following CalOptima programs:

Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

**L1: CONTRACTING WITH CALOPTIMA**

CalOptima members access their Medi-Cal health care benefits through a contracted health network, CalOptima’s fee-for-service program called CalOptima Direct (COD), or CalOptima’s managed networks called CalOptima Community Network (CCN). OneCare Connect members access their Medicare and Medi-Cal benefits through a contracted health network or through CalOptima.

1. **Health Networks** — CalOptima contracts with 11 health networks comprised of health maintenance organizations (HMOs), physician-hospital consortia (PHCs) and shared risk groups (SRGs). In general, each health network is responsible for providing a broad range of services, including physician and other professional services.

2. **CalOptima Direct** — CalOptima Direct (COD) is a fee-for-service program administered by CalOptima. This program serves members who meet eligibility criteria, such as share of cost members, dually eligible beneficiaries (members eligible with both Medicare and Medi-Cal) and foster children. CalOptima Direct also provides benefits to new members transitioning to a health network and members in long-term care facilities.

3. **CalOptima Community Network (CCN)** — A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a primary care provider (PCP) to manage the care of the members.

4. **OneCare Connect (OCC)** — OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. It is for people with both Medicare and Medi-Cal.

**As a result, providers have several options to serve CalOptima’s Medi-Cal members:**

1. **Contract with a Health Network** — Providers can contract with any of CalOptima’s 11 health networks.

2. **Participate through CalOptima Direct on a Non-Contracted Basis** — Providers can serve CalOptima Direct members on a non-contracted basis. Non-contracted providers must complete CalOptima’s provider registration process and be willing to accept CalOptima payment.

3. **Contract with the CalOptima Community Network (CCN)** — The CalOptima Community Network is designed to ensure that all members in this network have a primary care provider (PCP) who is accountable for coordinating all aspects of the member’s care, including making referrals to contracted specialists. CalOptima Community Network members have the opportunity to select a contracted PCP of their choice, or they are assigned to a PCP if they do not make a selection.

4. **Contract with OneCare Connect (OCC)** — Providers can also contract with OneCare Connect in which members’ Medicare and Medi-Cal benefits are integrated into a single plan.
HOW TO CONTRACT WITH CALOPTIMA

1. **Contracting with a Health Network** — If a physician or other provider is interested in contracting with one of CalOptima’s health networks, the provider should contact the health network directly to inquire about contracting opportunities. For CalOptima health network contact information, see Section: B1: CalOptima Department and Program Contact Information.

2. **Contracting with CalOptima Community Network or OneCare Connect** — If a physician is interested in participating in the CalOptima Community Network or OneCare Connect, he or she should call CalOptima’s Provider Resource line at 714-246-8600 to obtain more information.

3. **Registering with CalOptima Direct** — Providers and practitioners serving CalOptima Direct members need to complete CalOptima’s provider registration process. For more information about the provider registration process, please refer to Section L2: Provider and Practitioner Registration.

Providers with questions about contracting with CalOptima can call the CalOptima Provider Resource line at 714-246-8600 to obtain more information.
L1: CONTRACTING WITH CALOPTIMA

OneCare (HMO SNP) and OneCare Connect contract with a network of designated health networks to furnish members a broad array of professional services, including physician services. Providers may contract with OneCare (HMO SNP) or OneCare Connect through one of CalOptima’s contracted health networks.

HOW TO CONTRACT WITH ONECARE (HMO SNP) OR ONECARE CONNECT

If a provider is interested in contracting with OneCare (HMO SNP) or OneCare Connect through a health network, the provider should contact OneCare (HMO SNP)’s or OneCare Connect’s contracted health networks to inquire about contracting opportunities. For OneCare (HMO SNP) and OneCare Connect health network contact information, see Section B1: CalOptima Department and Program Contact Information of this manual.

Providers with questions about contracting with OneCare (HMO SNP) or OneCare Connect can call the CalOptima Provider Resource Line at 714-246-8600 to obtain more information.
L2: PROVIDER AND PRACTITIONER REGISTRATION

CalOptima requires providers and practitioners furnishing services to CalOptima Direct and OneCare Connect members to register with CalOptima. CalOptima uses the provider registration process to support accurate and timely adjudication of CalOptima Direct and OneCare Connect claims. New providers and practitioners can register for the first time with CalOptima through our website (www.caloptima.org/), while existing providers can make changes to their registration information online, by phone or fax.

There is no formal provider registration process for providers submitting claims to OneCare (HMO SNP). If you are interested in becoming a participating provider or practitioner with the OneCare (HMO SNP) program, please contact one of our contracted health networks for contracting opportunities.

HOW TO REGISTER FOR THE FIRST TIME WITH CALOPTIMA

New providers and practitioners can register online through CalOptima’s website at www.caloptima.org/.

Providers registering online must meet identified conditions or provide the following information:

1. Active status with DHCS
2. National Provider Identifier (NPI)
3. Tax Identification Number (TIN)
4. State medical license
5. Malpractice/liability insurance information (carrier and aggregate amounts)
6. DHCS certification license (if applicable)
7. Service address and phone number
8. Supervising physician name and license number (if applicable for non-physician medical practitioners)

HOW TO CHANGE AN EXISTING PROVIDER’S REGISTRATION INFORMATION

1. Existing providers may change their registration information by:
   a. Emailing CalOptima Provider Registration at provideronline@caloptima.org
   b. Faxing the provider’s new information to 714-954-2330

2. The types of changes that the provider or practitioner may make to his or her registration information include:
   a. Terminations
   b. Additional addresses
   c. Phone/fax/email updates
   d. Tax Identification Number (TIN) changes (requires submission of a new W9 form)
M1: Credentialing and Recredentialing

To help ensure a quality health care delivery system, CalOptima requires new providers (including physicians and non-physicians) to be credentialed as part of the contracting process with CalOptima or one of its health networks. CalOptima also requires its providers to be recredentialed every three years.

Health Network Providers — CalOptima requires its contracted health networks to credential their own providers. As a result, providers wishing to participate with one of CalOptima’s health networks must complete the specific health network’s credentialing process. If the provider receives a credentialing packet from a health network, he or she must complete the application and any other requested materials, and return the requested items to the health network. For health network contact information, see Section B2: Health Network Contact Information/Medi-Cal Program.

CalOptima Community Network (CCN) Providers — If a provider intends to participate in CCN as a contracted provider, he or she must complete CalOptima’s credentialing process.

Mid-Level Providers — CalOptima and its health networks credential mid-level providers. Mid-levels must be supervised by a credentialed physician and under a delegation services agreement or supervisory agreement.

Minimum Physician Standards — CalOptima requires all physicians to submit a CalOptima Minimum Physician Standards Attestation prior to completing a California Participating Physician Application for both CCN and delegated health networks.

Information Reviewed During Credentialing Process — In conducting the credentialing and recredentialing processes, CalOptima and its health networks verify specific information including, but not limited to, the following, as applicable:

1. California Participating Physician Application
2. California licensure
3. Current professional malpractice liability insurance and/or self-insurance
4. Affiliations such as hospitals, skilled nursing and long-term care facilities
5. Exclusions, suspensions or ineligibility to participate in any state or federal health care program
6. Enrolled as a Medi-Cal provider
7. Valid Drug Enforcement Agency (DEA) certificate
8. Education and training, including board certification
9. Work history
Full Scope Facility Site Review (FSR) — In conjunction with the credentialing process, CalOptima also conducts a full scope facility site review (FSR), medical records review (MRR) and physical accessibility review survey (PARS) of all new primary care sites, as required by the California Department of Health Care Services. CalOptima conducts an FSR every three years for each primary care site. For more information on these reviews, please refer to Section M2: Facility Site Review, Medical Record Review and Physical Accessibility Review Survey.

HOW TO COMPLETE THE INITIAL CREDENTIALING PROCESS

Providers interested in contracting with CalOptima Community Network must be credentialed by CalOptima if not credentialed with one of our delegated health networks. AppCentral is CalOptima’s online system for process credentialing applications electronically. To begin the credentialing application process, please follow the steps below:

For Practitioners: To begin the process, visit the CalOptima website, navigate to the Providers page and click the link “Begin Practitioner’s Initial Credentialing Application Process” in the Credentialing section. CalOptima uses the service AppCentral for completing the Initial Application Process.

1. From the link, you will be directed to create a user account with AppCentral. Once the user account has been created, the user will be directed to AppCentral and have access to further instructions and all documents needed to begin credentialing.

2. If the provider intends to contract as a primary care practitioner, CalOptima staff will contact the practitioner to schedule a full scope facility site review. For more information, refer to Section M2: Facility Site Review, Medical Record Review and Physical Accessibility Review Survey.

3. If the practitioner intends to contract as a high volume specialty, CalOptima staff will contact the practitioner to schedule a Physical Accessibility Review. For more information, refer to Section M2: Facility Site Review, Medical Record Review and Physical Accessibility Review Survey.

CalOptima will render a decision within 180 calendar days from the date the application attestation was signed, and practitioner will receive an official letter of credentialing approval.

HOW TO COMPLETE THE RECREDCREDENTIALING PROCESS

1. At the time of recredentialing (every three years after initial approved credentialing date), and if the practitioner has contracted with CCN, they will be contacted to confirm contact information of both the practitioner and his/her credentialing contact.

2. Once email addresses are confirmed, an invitation to AppCentral will be emailed. If a user account has not yet been created, a new one will need to be created allowing access to AppCentral. Once in AppCentral, the practitioner will be able to both review and or update the available California Participating Physician Application, as well as submit required documents for verification.

3. CalOptima staff will contact the provider about scheduling the full scope facility site review. For more information, see Section M2: Facility Site Review, Medical Record Review and Physical Accessibility Review Survey.
Accessibility Review Survey.

CalOptima will render a decision within 180 calendar days from the date the application attestation was signed, and practitioner will receive an official letter of recredentialing approval.

For questions regarding the credentialing or recredentialing process, call CalOptima’s Provider Resource Line at 714-246-8600.

**CalOptima Policies and Procedures:**
- GG.1606: Credentialing and Recredentialing of Mid-Level Practitioners
- GG.1609: Credentialing and Recredentialing
- MA.7009: Credentialing and Recredentialing
- MA.7009a: Credentialing and Recredentialing of Mid-Level Practitioners
M2: Facility Site Review, Medical Records Review, and Physical Accessibility Review Survey

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

M2: FACILITY SITE REVIEW, MEDICAL RECORDS REVIEW AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima conducts a full scope facility site review, which includes a facility site review (FSR), medical records review (MRR) and physical accessibility review survey (PARS) of primary care provider (PCP) sites, high volume specialists, and its provider credentialing and recredentialing process. The purpose of the FSR, MRR and PARS is to ensure that CalOptima PCPs meet certain minimum state required standards for their office sites for maintenance of patient medical records and to ensure physical accessibility for members with disabilities.

CalOptima conducts a full scope facility site review and PARS during the initial provider credentialing process and every three years thereafter.

KEY POINTS REGARDING THE FSR, MRR AND PARS

1. The FSR includes an on-site inspection and interviews with office personnel.

2. The MRR is based upon a survey of 10 randomly selected medical records per PCP and is comprised of five pediatric and five adult (or obstetric) records. The MRR review includes, but is not limited to, a review of format, legal documentation practices, and documentary evidence of the provision of preventive care and coordination of primary care services.

3. The PARS surveys the facility site access for members with disabilities to parking, the building, elevators, doctor’s office, exam rooms and restrooms. The survey will also identify if an exam room has a height adjustable exam table and accessible weight scale for those with disabilities.

4. CalOptima will not review a site if:
   a. The PCP site received a current passing score on a survey conducted by another Medi-Cal managed care health plan or the Department of Health Care Services (DHCS).

5. CalOptima has minimum standards for maintaining member medical records. The following are some of the required elements for maintaining member medical records. For more information on maintaining member medical records, refer to CalOptima Policy GG.1603 Medical Records Maintenance.
   a. Designate an individual responsible for the medical records system.
   b. Label and file all active records in the system to facilitate retrieval on demand.
   c. Store active records in a secure area.
   d. Retain inactive records for five years.
   e. File in the medical record within 48 hours of receipt: lab, X-ray, EEG, EKG, consultation reports, hospital and ED reports.

Section M: Quality Improvement
f. Date and sign medical records after each encounter.

g. Have a system in place to identify, monitor and follow up on members who do not keep appointments (no shows).

h. Maintain confidentiality of medical records.

6. To help providers prepare for upcoming full scope facility site reviews, CalOptima offers advance educational reviews for providers and their office staff. To schedule an advance educational review in preparation for an upcoming site visit, call CalOptima’s Provider Resource Line at 714-246-8600.

7. If CalOptima identifies deficiencies during the full scope facility site review, CalOptima will give the provider office a Corrective Action Plan, which will include specific time frames for addressing identified deficiencies. CalOptima will not allow provider sites with major uncorrected deficiencies to provide care to its members until the identified deficiencies have been corrected.

For more information about the full scope facility site review process, call CalOptima’s Provider Resource Line at 714-246-8600, Monday through Friday, from 8 a.m. to 5 p.m.

<table>
<thead>
<tr>
<th>CalOptima Policies and Procedures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG.1603: Medical Records Maintenance</td>
</tr>
<tr>
<td>GG.1608: Full Scope Site Reviews</td>
</tr>
<tr>
<td>GG.1608a: Facility Site Review Process</td>
</tr>
<tr>
<td>GG.1608b: Medical Records Review Process</td>
</tr>
<tr>
<td>MA.7011: Full Scope Practitioner Office Site Review</td>
</tr>
<tr>
<td>MA.7011b: Medical Records Review Process</td>
</tr>
</tbody>
</table>
M3: INITIAL HEALTH ASSESSMENT

All CalOptima members must receive an Initial Health Assessment (IHA) within 120 calendar days of enrollment with CalOptima. For members under the age of 18 months, the member shall receive an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages 2 and younger, whichever is less. CalOptima requires providers to administer an Individual Health Education Behavioral Assessment (IHEBA) as a part of the IHA.

The IHA is a comprehensive assessment that is completed during the member’s initial visit(s) with his or her primary care provider, appropriate medical specialist or non-physician medical provider. The purpose of the IHA is to assess and set the baseline for managing the acute, chronic and preventive health needs of the member.

The IHA must be documented in the member’s medical record and should be reviewed annually by the member’s provider.

TIPS FOR COMPLETING THE IHA

1. **What Should Be Included in the IHA?** — The IHA should include the following elements:
   a. Comprehensive History — The comprehensive history should include, but not be limited to:
      i. Member’s history of present illness
      ii. Member’s past medical history
      iii. Member’s social history
      iv. Review of the member’s organ systems
   b. Preventive Services for asymptomatic members
      i. For members age 21 and older, the IHA should include preventive screening, testing and counseling in accordance with the Guide of Clinical Preventive Services of the U.S. Preventive Services Task Force.
      ii. For members under age 21, include:
         - Age-specific assessments and services required by the Child Health and Disability Prevention Program (CHDP) and as specified by the American Academy of Pediatrics (AAP)
         - Assessments that follow the AAP periodicity schedule for examinations occurring more frequently than allowed under the CHDP schedule
      iii. The IHA should include perinatal services in accordance with guidelines of the American Congress of Obstetricians and Gynecologists (ACOG).
   c. A comprehensive physical and mental health status exam
   d. Diagnoses and a plan of care that includes follow-up activities
   e. An Individual Health Education Behavioral Assessment (IHEBA)
      i. The provider should administer the IHEBA utilizing the Staying Healthy Assessment (SHA) or other tool approved by CalOptima and the Department of Health Care Services (DHCS).
ii. To properly monitor and evaluate use of the SHA, providers should use the following codes:

- 99406 (non-billable): Smoking cessation intervention codes to be used for identification or brief education and counseling (3–10 minutes)
- 99407 (non-billable): Smoking cessation intervention codes to be used for identification or brief education and counseling (>10 minutes)
- 96150: Staying Healthy Assessment — Initial Visit
- 96151: Staying Healthy Assessment — Subsequent Visit
- H0049: Screening, Brief Intervention, and Referral to Treatment — Screening
- H0050: Screening, Brief Intervention, and Referral to Treatment — Brief Intervention

2. Where Can an IHA Be Performed? — An IHA may be performed in the following settings:
   a. In the physician or provider's office or other ambulatory care settings
   b. At a skilled nursing facility, especially for members residing in a nursing facility upon enrollment with CalOptima
   c. In the member’s home, particularly for homebound members
   d. In a hospital (note that any physical findings from the hospitalization must be rechecked and documented in a post-hospital discharge outpatient visit)

3. How Should the IHA Be Documented?
   a. The provider should document the IHA in the member’s medical record.
   b. The provider should remember to document all elements of the IHA, or if the provider believes the member should be exempt from the IHA (see below), the reasons for the exemption.

4. Which Members Are Exempt from the IHA? Selected members may be exempt from the IHA requirement under the following conditions:
   a. All elements of the IHA have been completed within 12 months of the member’s effective date of enrollment, and the provider has reviewed/updated the member’s medical record.
   b. If the provider can incorporate relevant information from the member’s existing medical record and has received a physical exam within 12 months of the member’s effective date of enrollment
   c. The member has not been continuously enrolled with CalOptima for 120 days.
   d. The member loses his or her eligibility prior to performance of the IHA.
   e. The member refuses the IHA (and the provider documents the refusal in the medical record).
   f. The member refuses the SHA (and the provider documents the refusal on the age-appropriate SHA questionnaire within the medical record).
   g. The member misses the scheduled appointment and two additional documented attempts to reschedule are unsuccessful.

CalOptima Policies and Procedures:
GG.1203: Initial Health Education Behavioral Assessments
GG.1613: Initial Health Assessment
M4: CLINICAL PRACTICE GUIDELINES

CalOptima encourages its providers to practice evidence-based medicine. CalOptima has links to clinical practice guidelines available to address conditions frequently seen in patients at your practice. All clinical practice guidelines included have been reviewed and approved by CalOptima’s Quality Improvement Committee and Utilization Management Committee.

All guidelines are connected to links that are simple to access and include algorithms for quick reference. A detailed document accompanies each algorithm. CalOptima is confident providers will find these clinical practice guidelines valuable to their daily practice.

RECOMMENDED CLINICAL PRACTICE GUIDELINES

Providers can view CalOptima’s clinical practice guidelines on CalOptima’s website at www.caloptima.org/.
This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

M5: HEDIS MEASURES AND REPORTING

OVERVIEW

HEDIS® stands for the Health Care Effectiveness Data and Information Set, which is a set of standardized measures developed by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care. It allows for assessment based on quality and performance. Altogether, HEDIS consists of 95 measures across seven domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are increasingly used to track year-to-year performance. HEDIS is one component of NCQA's accreditation process, although some plans submit HEDIS data without seeking accreditation. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare Advantage members.

CalOptima is required to report HEDIS rates to the California Department of Health Care Services (DHCS), CMS and the NCQA annually. Data obtained from HEDIS helps CalOptima to direct its quality improvement activities, evaluate performance and identify further opportunities for improvement.

Data Collection Methods

HEDIS measures are specified for one or more of three data collection methods:

- Administrative Method: Members who are found through administrative (electronic) data to have received the service required for the numerator.
- Hybrid Method: The organization collects and reviews medical records to supplement administrative data to determine if members received the service required for the numerator.
- Survey Method: Requires organizations to collect data through a survey. Survey measure results are obtained through a certified survey vendor.
- Electronic Clinical Data Systems (ECDS): ECDS are a network of databases containing a plan member’s personal health information and records of their experiences within the health care system. The ECDS reporting standard represents a step forward in adapting HEDIS to accommodate the expansive information available in electronic clinical datasets for quality improvement.

Each year, health plans collect and report HEDIS data through a series of coordinated activities, including computer programming, encounter and claims analysis, and data integration through a certified HEDIS software vendor. For all measures designated as hybrid by NCQA, CalOptima also collects and reviews medical records.
From late February to early May, the contracted copy service contacts provider offices to retrieve medical records. Abstractors review the medical records to determine if the member received the service required for the numerator. If the service is not documented, further research is done to determine if CalOptima received a complete chart from the provider’s office or if a different office should be contacted to obtain additional records.

Why Is it Important to Members and Practitioners? Measuring health care services allows CalOptima to develop initiatives to improve the health of members based upon their health care needs. Quality programs serve to increase member awareness and understanding of preventive health care, health care screenings and appropriate care for specific conditions. Throughout the HEDIS data collection process, we maintain every member’s confidentiality at the highest level following all Health Insurance Portability and Accountability Act (HIPAA) regulations.

HEDIS Tips for Practitioners
CalOptima may contact selected medical offices to review patient medical records as part of the HEDIS medical records review process. Here are HEDIS tips for physicians:

1. Practitioners should keep accurate, legible and complete medical records for their patients. Each document in the medical record must contain the member name and date of birth (DOB) to be acceptable for HEDIS. If paper charts are used, the member’s full name and DOB should be documented on every page (front and back).
2. Practitioners need to encourage patients to receive appropriate preventive services to ensure their health and well-being. For many measures, a well visit is not required; if all well-care components have been performed at a sick visit (or over multiple sick visits), a member is considered to have had appropriate preventive services. If a service is declined by the member, providers may document it on the chart.
3. Since HEDIS reporting is mandated by the California DHCS, CMS and the NNCQA for compliance, practitioners and their staff should become familiar with HEDIS measures to understand what health plans are required to report.

Frequently Asked Questions (FAQ) Regarding Medical Record Collection

1. We submit claims and encounters; why does CalOptima need medical records?
   HEDIS requires us to provide data to calculate the quality of care for different measures. Examples of these measures include diabetes care, immunization status, prenatal and postpartum care and controlling blood pressure. Some of the data required is not available on the claims submitted by providers and other health care partners. We can obtain it only through chart reviews.

2. What is my responsibility in the data collection process?
   HEDIS is a time-sensitive project. It is very important that providers respond to the requests for medical record documentation in a timely manner to ensure CalOptima can report complete and accurate rates. The contracted HEDIS vendor will contact the provider office to establish a date for on-site, fax, upload to their secure website or mail data collection. CalOptima will supply the provider office with a patient list so the requested medical records can be made available for the on-site visit or for faxing/uploading/mailing the documentation. If a member on the list is a member that has not been seen in the provider’s office, providers may indicate “Patient Never Seen” next to the name on the list and return the form to the contracted vendor.

3. What are Risk Adjustment record reviews and are they the same as HEDIS?
   No, Risk Adjustment reviews are not the same as HEDIS. Risk Adjustment reviews capture medical record documentation to determine a Medicare patient’s health status and ultimately ensure accurate coding and reimbursement. It is possible that providers will receive both a Risk Adjustment request and a HEDIS request for the member.

4. Is my participation in HEDIS data collection mandatory?
Yes. All health networks, medical groups and medical offices that have provided services to CalOptima members are required to provide medical record information so that we may fulfill our state and federal regulatory and accreditation obligations. Contractually, practitioners are obligated to allow the plan access for reviewing medical records.

5. **Should I allow a record review for a member who is no longer with CalOptima or for a member who is deceased?**
   Yes. Medical record reviews may require data collection on services obtained over multiple years.

6. **Am I required to provide medical records for a member who was seen by a physician who has retired, died or moved?**
   Yes. HEDIS data collection includes reviewing medical records as far back as 10 years. Archived medical records and data may be required to complete data collection.

7. **Does HIPAA permit me to release records to a CalOptima representative or designated vendor for HEDIS data collection?**
   Yes. As a CalOptima business associate, providers are permitted to disclose protected health information (PHI) to the vendors who are acting on our behalf. A signed consent form from the member is not required under the HIPAA privacy rule for providers to release the requested information to the vendors. Data used for treatment, payment and health care operations may be disclosed without member consent. HEDIS falls under “health care operations.” In addition, CalOptima members sign a medical records release form at the time of enrollment so that it is not necessary for a practitioner to obtain a release. The following link provides more information about the HIPAA privacy rule: [www.hhs.gov/](http://www.hhs.gov/)

8. **What can I expect if my member(s) have been selected for Medical Record Review?**
   After contacting the provider office to verify the fax number, the copy service company will fax the provider a letter of representation, list of member’s names for whom we will need medical records along with HEDIS Measures Records Needed Document to help with the record retrieval process. Please work directly with the copy service to coordinate the retrieval method (fax, upload, mail or on-site scanning). If those options don’t work for the provider office, they may notify CalOptima immediately and we will work with the provider office to accommodate their needs.

   - If a provider office has transitioned or is in the middle of transitioning to an electronic medical record (EMR), notify the copy service and assist them in locating the service in the EMR. Providers should be familiar with their EMR. Make sure that all pertinent information is properly displayed when printing. For example, if providers know they can enter the height and weight and the system automatically calculates the body mass index (BMI) but it’s not displayed when the progress note prints out, providers may take a print screen of the data entry and submit it to CalOptima along with the medical record.
   - If the practice has more than one location and providers are aware the member was seen at the other locations, please forward the request to the appropriate office and notify the copy service.
   - If dates of service are missing or additional information is needed to accurately reflect the services rendered, CalOptima may call to confirm if the office has the appropriate information.

If providers have questions about HEDIS measures or data collection, call CalOptima’s Provider Resource Line at **714-246-8600**.
This section applies to the following CalOptima programs:

Medi-Cal

M6: ACCESS STANDARDS

CalOptima adheres to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). The DHCS and DMHC implemented these standards to ensure that Medi-Cal beneficiaries can get an appointment for care on a timely basis, can reach the provider over the phone and can access interpreter services, as needed.

Contracted providers and health networks are expected to comply with these appointment, telephone access, practitioner availability and linguistic service standards. CalOptima monitors its health networks and providers for compliance with these standards. CalOptima will develop corrective action plans for providers and health networks that do not meet these standards. Please refer to CalOptima Policy GG.1600: Access and Availability Standards for more information related to CalOptima’s process for monitoring access and availability standards.

UNDERSTANDING THE ACCESS STANDARDS

What follows is a brief description of the access standards for CalOptima Medi-Cal members:

Access to Emergent/ Urgent Medical Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Immediately, 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Within 24 hours of request</td>
</tr>
</tbody>
</table>

Access to Primary Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Appointments that DO NOT Require Prior Authorization</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Non-Urgent Primary Care</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Routine Physical Exams and Wellness Visits</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Initial Health Assessment (IHA) or Individual Health Education Behavioral Assessment (IHEBA)</td>
<td>Within 120 calendar days of Medi-Cal enrollment</td>
</tr>
</tbody>
</table>
Access to Specialty and Ancillary Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Appointments that DO Require Prior Authorization</td>
<td>Within 96 hours of request</td>
</tr>
<tr>
<td>Non-Urgent Specialty Care</td>
<td>Within 15 business days of request</td>
</tr>
<tr>
<td>First Prenatal Visit</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Non-Urgent Ancillary Services</td>
<td>Within 15 business days of request</td>
</tr>
</tbody>
</table>

Access to Behavioral Health Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Care with a Non-Physician Behavioral Health Provider</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Follow-up Routine Care with a Non-Physician Behavioral Health Provider</td>
<td>Available to member within clinically reasonable time frames. Behavioral health providers will assess the clinically appropriate treatment and provide follow-up services within the scope of their practice.</td>
</tr>
</tbody>
</table>

Telephone Access Standards:

<table>
<thead>
<tr>
<th>Telephone Access</th>
<th>Wait Time or Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Triage</td>
<td>Telephone triage shall be available 24 hours a day, seven days a week. Telephone triage or screening waiting time shall not exceed 30 minutes.</td>
</tr>
<tr>
<td>Telephone Wait Time During Business Hours</td>
<td>A non-recorded voice within 30 seconds.</td>
</tr>
<tr>
<td>Urgent Message During Business Hours</td>
<td>Practitioner returns the call within 30 minutes after the time of message.</td>
</tr>
<tr>
<td>Non-emergency and Non-urgent Messages During Business Hours</td>
<td>Practitioner returns the call within 24 hours after the time of message.</td>
</tr>
<tr>
<td>Telephone Access After Business Hours</td>
<td>The phone message must instruct members to dial 911 or go to the nearest emergency room.</td>
</tr>
<tr>
<td>After-hours Access</td>
<td>A primary care provider (PCP) or designee shall be available 24 hours a day, seven days a week to respond to after-hours member calls or to a hospital emergency room practitioner.</td>
</tr>
</tbody>
</table>
### Cultural and Linguistic Standards:

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Interpretation</td>
<td>Oral interpretation including, but not limited to, sign language, shall be made available to members at key points of contact through an interpreter in person (upon a member’s request) or by telephone, 24 hours a day and seven days a week.</td>
</tr>
<tr>
<td>Written Translation</td>
<td>All written materials to members shall be available in threshold languages as determined by CalOptima in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.</td>
</tr>
<tr>
<td>Alternative Forms of Communication</td>
<td>Informational and educational information for members in alternative formats will be available at no cost in the threshold languages in at least 14 point font, audio format or braille upon request, or as needed within 21 days of request or within a timely manner for the format requested.</td>
</tr>
<tr>
<td>Telecommunications Device for the Deaf</td>
<td>Telecommunications Device for the Deaf (TDD) or California Relay Services (CRS) and auxiliary aids shall be available to members with hearing, speech or sight impairments at no cost, 24 hours a day and seven days a week. The TDD/TTY toll-free number is 1-800-735-2929.</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>Practitioners and staff shall encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these beliefs into treatment plans.</td>
</tr>
</tbody>
</table>

### Other Access Standards:

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Accessibility</td>
<td>Members with disabilities shall have access that includes, but is not limited to: ramps, elevators, restrooms, designated parking spaces and drinking water provision.</td>
</tr>
<tr>
<td>In-office Wait Time for Appointments</td>
<td>Less than 45 minutes before being seen by a provider</td>
</tr>
<tr>
<td>Rescheduling Appointments</td>
<td>Appointments will be rescheduled in a manner appropriate to the member’s health care needs and that ensures continuity of care is consistent with good professional practice.</td>
</tr>
<tr>
<td>Sensitive Services</td>
<td>A member may self-refer to an out-of-network provider to receive sensitive services without prior authorization.</td>
</tr>
<tr>
<td>Minor Consent Services</td>
<td>Available to a member under the age of 18 in a confidential manner without parental consent.</td>
</tr>
<tr>
<td>Description</td>
<td>Standard</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>A member shall have direct access to OB/GYN and family planning services, according to CalOptima Policy GG.1508: Authorization and Processing of Referrals.</td>
</tr>
</tbody>
</table>

**Moral or Ethical Objection:** In the event a provider has a moral or ethical objection to providing a covered service to a member, CalOptima or a health network shall refer the member to a different provider at no extra cost to CalOptima.

**CalOptima Policies and Procedures:**
- GG.1118: Family Planning Services, Out-of-Network
- GG.1508: Authorization and Processing of Referrals
- GG.1600: Access and Availability
M6: ACCESS STANDARDS

OneCare and OneCare Connect are required to adhere to patient care access and availability standards as required by the Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS). DMHC and CMS have implemented these standards to ensure that OneCare and OneCare Connect members can get an appointment for care on a timely basis, can reach the provider over the phone and can access interpreter services, as needed.

Contracted physicians and health networks are expected to comply with these appointment, telephone access, practitioner availability and linguistic service standards. OneCare and OneCare Connect monitors its health networks and providers for compliance with these standards. OneCare and OneCare Connect may develop a corrective action plan for providers and health networks that do not meet these standards. Please refer to CalOptima Policy MA. 7007: Access and Availability Standards, for more information related to CalOptima’s process for monitoring access and availability standards.

UNDERSTANDING THE ACCESS STANDARDS

What follows is a brief description of the access standards for OneCare (HMO SNP) and OneCare Connect (Cal MediConnect) members:

Access to Emergent/ Urgent Medical Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Wait Time or Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Immediately, 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Within 24 hours of request</td>
</tr>
</tbody>
</table>

Access to Primary Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Appointments that DO NOT Require Prior Authorization</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Non-Urgent Primary Care</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Routine Physical Exams and Health Assessments</td>
<td>Within 30 calendar days of request</td>
</tr>
</tbody>
</table>
Access to Specialty and Ancillary Care:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Appointments that DO Require Prior Authorization</td>
<td>Within 96 hours of request</td>
</tr>
<tr>
<td>Non-Urgent Specialty Care</td>
<td>Within 15 business days of request</td>
</tr>
<tr>
<td>First Prenatal Visit</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Non-Urgent Ancillary Services</td>
<td>Within 15 business days of request</td>
</tr>
</tbody>
</table>

Access to Behavioral Health Care

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Care with a Non-Physician Behavioral Health Provider</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Follow-up Routine Care with a Non-Physician Behavioral Health Provider</td>
<td>Available to member within clinically reasonable time frames. Behavioral health providers will assess the clinically appropriate treatment and provider follow-up services within the scope of their practice.</td>
</tr>
</tbody>
</table>

Telephone Access Standards:

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Triage</td>
<td>Telephone triage shall be available 24 hours a day, seven days a week. Telephone triage or screening waiting time shall not exceed 30 minutes.</td>
</tr>
<tr>
<td>Telephone Wait Time During Business Hours</td>
<td>A non-recorded voice within 30 seconds</td>
</tr>
<tr>
<td>Urgent Message During Business Hours</td>
<td>Practitioner returns the call within 30 minutes after the time of message.</td>
</tr>
<tr>
<td>Non-emergency and Non-urgent Messages During Business Hours</td>
<td>Practitioner returns the call within 24 hours after the time of message.</td>
</tr>
<tr>
<td>Telephone Access After Business Hours</td>
<td>The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room.</td>
</tr>
<tr>
<td>After-hours Access</td>
<td>A primary care provider (PCP) or designee shall be available 24 hours a day, 7 days a week to respond to after-hours member calls or to a hospital emergency room practitioner.</td>
</tr>
</tbody>
</table>
**Cultural and Linguistic Standards:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Interpretation</td>
<td>Oral interpretation including, but not limited to, sign language shall be made available to members at key points of contact through an interpreter in person (upon a member’s request) or by telephone, 24 hours a day and seven days a week.</td>
</tr>
<tr>
<td>Written Translation</td>
<td>All written materials to members shall be available in threshold languages as determined by CalOptima in accordance with CalOptima policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.</td>
</tr>
<tr>
<td>Alternative Forms of Communication</td>
<td>Informational and educational information for members in alternative formats will be available at no cost in the threshold languages in at least 12point font, audio format, or braille upon request, or as needed, within 21 business days of request or within a timely manner for the format requested.</td>
</tr>
<tr>
<td>Telecommunications Device for the Deaf</td>
<td>Telecommunications Device for the Deaf (TDD) or California Relay Services (CRS) and auxiliary aids shall be available to members with hearing, speech or sight impairments at no cost, 24 hours a day and 7 days a week. The TDD/TTY Line is 1-800-735-2929.</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>Practitioners and staff shall encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these beliefs into treatment plans.</td>
</tr>
</tbody>
</table>
### Other Access Standards:

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Accessibility</td>
<td>Members with disabilities shall have access that includes, but is not limited to: ramps, elevators, restrooms, designated parking spaces and drinking water provision.</td>
</tr>
<tr>
<td>In-office Wait Time for Appointments</td>
<td>Less than 45 minutes before being seen by a provider</td>
</tr>
<tr>
<td>Rescheduling Appointments</td>
<td>Appointments will be rescheduled in a manner appropriate to the member’s health care needs and that ensures continuity of care is consistent with good professional practice.</td>
</tr>
<tr>
<td>Sensitive Services</td>
<td>A member may self-refer to an out-of-network provider to receive sensitive services without prior authorization.</td>
</tr>
<tr>
<td>Minor Consent Services</td>
<td>Available to a member under the age of 18 in a confidential manner without parental consent</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>A member shall have direct access to OB/GYN and family planning services, according to CalOptima Policy GG.1508: Authorization and Processing of Referrals.</td>
</tr>
</tbody>
</table>

**Moral or Ethical Objection:** In the event a provider has a moral or ethical objection to providing a covered service to a member, CalOptima or a health network shall refer the member to a different provider at no extra cost to CalOptima.

**CalOptima Policies and Procedures:**
- GG.1118: Family Planning Services, Out-of-Network
- GG.1508: Authorization and Processing of Referrals
- MA7007: Access and Availability and Availability Standards
M7: REPORTING POTENTIAL QUALITY OF CARE ISSUES

CalOptima monitors the quality of care provided to members by its health networks and providers. As a part of this monitoring effort, CalOptima has a process for identifying and receiving reports of potential quality of care issues. We perform case reviews, investigate potential quality of care issues and determine the severity of issues. Based upon these investigations, CalOptima determines the appropriate follow-up action required for individual cases. We also aggregate potential quality of care issues data to help identify problems within the provider network.

What Constitutes Potential Quality of Care Issues? — Potential quality of care issues may include any of the following types of cases:

1. A clinical issue or judgment that affects a member’s care and has the potential for an adverse effect. This may include:
   a. Delay in care or treatment, or delay in referral for testing or to a specialist that adversely affected the member’s health
   b. Unnecessary prolonged treatment, complications or readmission
   c. Patient management of lack of treatment results in significantly diminished health status, impairment, disability or death.
   d. An unexpected occurrence involving death or serious physical or psychological injury

Members, providers, practitioners, health networks and CalOptima staff may each report potential quality of care issues.

HOW TO REPORT A POTENTIAL QUALITY OF CARE ISSUE

1. The quality of care issue should be directed to:

   CalOptima
   Attention: Quality Improvement
   505 City Parkway West
   Orange, CA 92868

   Or qualityofcare@caloptima.org

   Please include the member’s name, CIN, provider’s full name, and a description of the issue or concern.

2. What Happens Once a Potential Quality of Care Issues Complaint Is Filed?
   a. Health Network Cases — If the case involves a health network member, CalOptima will request that the health network gather medical records and the providers respond to the complaint.
   b. CalOptima shall conduct a case review of the member’s medical records and provider’s response, and evaluate the issue.
a. **CalOptima Direct or OneCare Connect Cases** — If the case involves a CalOptima Direct or OneCare Connect member, CalOptima will request copies of the member’s medical record from the rendering provider, which must be provided within seven calendar days.

b. CalOptima shall conduct a case review of the member’s medical records and provider’s response, and evaluate the issue.

CalOptima’s physician reviewer will determine if a quality of care issue has occurred. If a quality issue exists, CalOptima’s Credentialing and Peer Review Subcommittee may request corrective action.

3. **Will the Provider or Party Filing the Complaint Hear About Resolution?** The reporting provider will not be informed of the outcome of the complaint. Only those directly involved in the case will be knowledgeable of the outcome.

If a provider has questions about filing a potential quality of care issue, call CalOptima’s Provider Resource Line at **714-246-8600**.

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**CalOptima Policies and Procedures:**

GG.1611: Quality Improvement Case Review Process

GG.1612: Outcome Scores for Potential Quality Issues
N1: ASSISTANCE FROM CALOPTIMA CUSTOMER SERVICE

CalOptima’s Customer Service department responds to the questions and needs of members, as well as answer questions from providers about their members. Customer Service also works closely with community agencies and organizations to coordinate care for CalOptima members.

Customer Service supports CalOptima’s providers by helping members to:

- Choose or change a primary care provider (PCP).
- Know how to access care within the managed-care system.
- Understand their benefits and how to access care.
- Communicate and work with their doctors.
- Recognize their rights and responsibilities as members.

Customer Service provides the following services, which assist both members and providers:

- **Call Center Services**: The Customer Service department call center handles incoming member and provider calls regarding eligibility, benefits, prior authorization status, coordination of care and other issues. Phone lines are staffed in several languages including English, Spanish, Vietnamese, Korean, Arabic, Chinese and Farsi. The call center staff assist daily walk-in members and provide coverage of the reception area.

- **Assistance for Seniors, People with Disabilities and Other Vulnerable Members**: The Member Liaison program assists seniors, people with disabilities or chronic conditions, and members without housing to access health care services by providing direct intervention and/or education for self-advocacy. The member liaison specialists work closely with providers and community agencies throughout Orange County to help guide members through the health care system.

- **Cultural and Linguistic Services**: Customer Service provides and facilitates interpretation and translation services. Interpreter services are necessary to assist many CalOptima members in communicating with their health care providers. Translation services are available in CalOptima’s threshold languages. Cultural and linguistic services also facilitate and provide training and cultural events to promote organization-wide cultural competency.

- **Member Communications**: Customer Service develops, produces and distributes Customer Service member communications and notifications for all CalOptima programs.

- **Data Management**: Customer Service maintains the integrity of member eligibility data through the daily reconciliation of reports and manual correction of data fallout. Additionally, Customer Service manages the data on member selections and changes of a health network, as well as data
on any selections and changes of a primary care provider (PCP) occurring with a health network change.

HOW TO CONTACT CALOPTIMA’S CUSTOMER SERVICE DEPARTMENT FOR ASSISTANCE

CalOptima’s Customer Service department can help providers with questions about CalOptima members. To reach Customer Service, call 714-246-8500, Monday through Friday, from 8 a.m. to 5:30 p.m.
N2: Member Liaison Program for Seniors and Persons with Disabilities (SPD)

This section applies to the following CalOptima programs:

- Medi-Cal, OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

**N2: MEMBER LIAISON PROGRAM FOR SENIORS AND PERSONS WITH DISABILITIES (SPD)**

The Member Liaison Program is dedicated to helping seniors, members with disabilities or chronic conditions, and members without housing access health care services. The member liaison specialists work closely with health care providers, case managers and agencies throughout Orange County to help guide CalOptima members through the health care system. They help members obtain proper care, timely referrals to services, and connect them with health and community resources by providing direct intervention and or education for self-advocacy. The Member Liaison Program also offers monthly New Member Orientation presentations in our threshold languages to welcome new members and educate them on CalOptima programs as well as accessing benefits and services through our contracted providers.

The member liaison specialists can assist your CalOptima members by:

1. Scheduling appointments with a doctor
2. Arranging for non-emergency medical transportation
3. Resolving medication issues
4. Obtaining durable medical equipment including wheelchairs, wheelchair repairs, crutches and other supplies

**HOW TO REFER MEMBERS TO THE MEMBER LIAISON PROGRAM**

If you have a patient who may benefit from services of the Member Liaison Program, or if you want to obtain more information about services offered by the Member Liaison Program, please contact CalOptima’s Customer Service department at **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m.

Providers can use the following aid codes to determine member eligibility for seniors and persons with disabilities (SPD):

<table>
<thead>
<tr>
<th>Eligible Member</th>
<th>Aid Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>53, 81, 86</td>
</tr>
<tr>
<td>Aged</td>
<td>10, 14, 16, 17, 1E, 1H</td>
</tr>
<tr>
<td>Blind/Disabled</td>
<td>20, 24, 26, 2E, 2H, 36, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 60, 64, 65, 66, 67</td>
</tr>
<tr>
<td>Breast and Cervical Cancer Treatment Program (BCCTP)</td>
<td>0M, 0N, 0P, 0R, 0T, 0U, 0W</td>
</tr>
<tr>
<td>Eligible Member</td>
<td>Aid Code</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>13,23,53,63</td>
</tr>
</tbody>
</table>

For training and additional resources regarding seniors and persons with disabilities (SPD), visit the Providers section of the CalOptima website.
N3: Health Network and Primary Care Provider (PCP) Selection

Section N: Customer Service

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

N3: HEALTH NETWORK AND PRIMARY CARE PROVIDER (PCP) SELECTION

OneCare (HMO SNP) is committed to ensuring that its members have ample opportunity to select a primary care provider (PCP) and a health network, both when they join OneCare and on an ongoing basis.

WHAT PROVIDERS SHOULD KNOW ABOUT THE SELECTION PROCESS

OneCare members select a health network and a PCP upon enrollment. The following outlines the major elements of the health network and PCP selection process.

1. Choice Upon Initial Enrollment Into OneCare (HMO SNP)
   a. New members to OneCare complete an enrollment form during the enrollment process and use the form to indicate a PCP and health network selection.
   b. New members to OneCare must select a PCP and health network at the time of enrollment.
   c. If a member does not select a PCP or health network, OneCare will assign the member to a PCP and or health network. OneCare will notify the member of the assignment, along with instructions about how to change the PCP or health network assignment.

2. PCP Selection/Changes
   a. New members to OneCare receive a Provider Directory insert that explains the process of selecting a PCP and health network.
   b. Members may choose any of the doctors listed in the OneCare (HMO SNP) Provider Directory as their PCP. If the PCP is not open to new members, we will ask the member to choose another PCP.
   c. Members may change their PCP and/or health network at any time by calling the OneCare Customer Service department at 877-412-2734. The new selection will be effective on the first of the month following the date OneCare receives the member’s request.

For questions or more information about OneCare’s provider and health network selection process, call OneCare’s Provider Resource Line at 714-246-8600, Monday through Friday, from 8 a.m. to 5 p.m.

CalOptima Policies and Procedures:
MA.4010: Physician Group and PCP Selection and Assignment
N4: MEMBER RIGHTS AND RESPONSIBILITIES

CalOptima is required to inform its members of their rights and responsibilities, and ensure that members’ rights and responsibilities are respected and observed. CalOptima provides this information to members in the Member Handbook upon enrollment, annually in the member newsletter, on CalOptima’s website and upon request.

Providers are required to post the members’ rights and responsibilities in the waiting room of the facility in which services are rendered.

CalOptima members have the right to:

1. Be treated with respect and dignity by all CalOptima and provider staff
2. Privacy and to have medical information kept confidential
3. Get information about CalOptima, our providers, the services they provide and their member rights and responsibilities
4. Choose a doctor within CalOptima’s network
5. Talk openly with health care providers about medically necessary treatment options, regardless of cost or benefit
6. Help make decisions about their health care, including the right to say “no” to medical treatment
7. Voice complaints or appeals, either verbally or in writing, about CalOptima or the care we provide
8. Get oral interpretation services in the language that they understand
9. Make an advance directive
10. Access family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and emergency services outside CalOptima’s network
11. Ask for a state hearing, including information on the conditions under which a state hearing can be expedited
12. Have access to their medical record and, where legally appropriate, get copies of, update or correct their medical record
13. Access minor consent services
14. Get written member information in large-size print and other formats upon request and in a timely manner appropriate for the format being requested
15. Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge

16. Get information about their medical condition and treatment plan options in a way that is easy to understand

17. Make suggestions to CalOptima about their member rights and responsibilities

18. Freely use these rights without negatively affecting how they are treated by CalOptima, providers or the state

**CalOptima members are responsible for:**

1. Knowing, understanding and following their member handbook

2. Understanding their medical needs and working with their health care providers to create their treatment plan

3. Following the treatment plan they agreed to with their health care providers

4. Telling CalOptima and their health care providers what we need to know about their medical condition so we can provide care

5. Making and keeping medical appointments and telling the office when they must cancel an appointment

6. Learning about their medical condition and what keeps them healthy

7. Taking part in health care programs that keep them healthy

8. Working with and being polite to the people who are partners in their health care

**HOW TO OBTAIN MORE INFORMATION ABOUT CALOPTIMA’S MEMBER RIGHTS AND RESPONSIBILITIES**

CalOptima’s Customer Service department can help providers with questions about CalOptima’s PCP and health network selection process. To reach Customer Service, call **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m.

**CalOptima Policies and Procedures:**

DD.2001: Member Rights and Responsibilities
This section applies to the following CalOptima programs:

Medi-Cal

N5: NEW MEMBER WELCOME MATERIALS

All CalOptima members receive an initial mailing when they first become a CalOptima member. Health network-eligible members receive Packet 1 (see information below). The packet contents may vary depending on whether a member is eligible for a health network, CalOptima Direct (COD)-Administrative Medi-Cal/Medicare, or CalOptima Community Network (CCN), as described in the packets below.

In the Packet 1 mailing, health network-eligible members also receive information to assist them in selecting a health network and primary care provider (PCP).

All Medi-Cal members receive a newsletter annually that includes articles on health education, services, benefits and information about how to use the health plan.

 PACKET 1: HEALTH NETWORK NEW MEMBER WELCOME PACKET

Packet 1 contents are sent to health network-eligible members within seven calendar days of the member becoming eligible with CalOptima.

Contents include:

1. New Member Welcome Letter/CalOptima Medi-Cal ID Card
2. Health Network Member Handbook
3. Health Network Selection Form
4. Health Network Selection Form Guide
5. Health Network New Member Orientation Invitation
6. Healthy You Initial Health Assessment
7. Notice of Nondiscrimination/Language Assistance Taglines
8. Health Information Form
9. Provider Directory

PACKET 2: CALOPTIMA DIRECT-ADMINISTRATIVE MEDI-CAL AND MEDICARE (MEDI-MEDI) NEW MEMBER WELCOME PACKET

Packet 2 contents are sent to COD-Administrative Medi-Medi members within seven calendar days of member becoming eligible with CalOptima.

Contents include:

1. COD Welcome Letter
2. CalOptima Medi-Cal ID Card (sent separately in its own mailing)

3. COD Member Handbook

4. COD New Member Orientation Invitation

5. Notice of Nondiscrimination/Language Assistance Taglines

6. Healthy You Initial Health Assessment

7. Health Information Form

**PACKET 3: CALOPTIMA DIRECT-ADMINISTRATIVE NEW MEMBER WELCOME PACKET**

Packet 3 contents are sent to CalOptima Direct-Administrative members within seven calendar days of member becoming eligible with CalOptima.

**Contents include:**

1. COD Welcome Letter

2. CalOptima Medi-Cal ID Card (sent separately in its own mailing)

3. COD Member Handbook

4. COD New Member Orientation Invitation

5. Notice of Nondiscrimination/ Language Assistance Taglines

6. Health Information Form
N5: NEW MEMBER WELCOME MATERIALS

Upon enrolling in OneCare, all new OneCare members receive two initial mailings that contain information to help members access OneCare’s programs and services.

All members also receive a newsletter annually with articles on health education, service and benefit reminders, and information about how to use the health plan.

PACKET 50: ONECARE WELCOME PACKET

The OneCare Welcome Packet is sent to eligible members within 10 calendar days after receipt of the completed enrollment form. Contents include:

1. Evidence of Coverage (EOC)
2. Acknowledgement of Completed Enrollment Letter
3. OneCare ID Card
4. Notice of Privacy Practices
5. Notice of Nondiscrimination
6. Multi-Language Insert
7. Provider Directory and Formulary Insert

PACKET 50A: ONECARE WELCOME SUBSEQUENT PACKET

1. New Member Orientation Invitation
2. Silver & Fit Welcome Letter and Brochure

PACKET 52: ONECARE NEW MEMBER WELCOME PACKET

The OneCare New Member Welcome Packet is sent to members within 10 calendar days after receipt of the enrollment confirmation from the Centers for Medicare & Medicaid Services. Contents include:

1. Confirmation of Enrollment Letter

OBTAINING MORE INFORMATION ABOUT THE NEW MEMBER MATERIALS

For questions about new member materials packets, or more information about any of the contents of the packets, call CalOptima’s Provider Resource Line at 714-246-8600, Monday through Friday, from 8 a.m. to 5 p.m.
N6: Obtaining Access to Cultural and Linguistic Services

State and federal regulations require CalOptima to make interpreter and translation services for limited English proficient (LEP) members available. CalOptima is also required to facilitate, promote and provide training in cultural competency for its staff, as well as for health network staff and CalOptima providers.

CalOptima’s Cultural and Linguistic Services program provides and facilitates interpreter and translation services, and also coordinates training and events to promote cultural sensitivity and competency.

The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) periodically audit CalOptima’s Language Assistance Program which includes interpreter and translation services, as well as on its conduct of cultural competency training. DHCS and CMS auditors may select individual provider offices to review as a part of this audit to verify whether LEP members are informed of the availability of language assistance and have been offered interpreter services. CalOptima will contact, in advance, provider offices selected by the DHCS to participate in its cultural and linguistic services audit.

Obtaining More Information About CalOptima’s Cultural and Linguistic Services

To register for CalOptima’s Awareness and Education Seminars, contact CalOptima’s Customer Service department at **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m. or email Cultural and Linguistic Services at: **culturallinguistic@caloptima.org**.
N7: ACCESSING INTERPRETER SERVICES

Federal and state regulations require CalOptima to provide interpreter services to members with limited English proficiency. Limited English proficient (LEP) members include those who have a limited ability to read, speak, write or understand English.

Providers may request interpreter services for their CalOptima patients with limited English proficiency. Providers may request either telephonic or face-to-face interpreter services, depending upon the situation.

For help in identifying your patient’s preferred language, see the Providers section of the CalOptima website.

HOW TO REQUEST INTERPRETER SERVICES

1. Verify the member’s eligibility and identify if the member is enrolled in a health network or CalOptima Direct.

2. Determine whether telephonic or face-to-face interpreter service is needed.
   a. Telephonic interpreter service is recommended for urgent situations or short and simple conversations. This service is available 24 hours a day, seven days a week.
   b. Face-to-face interpreter service, including sign language, is recommended when complicated or extensive explanation of treatment or symptoms is required. This service is available for scheduled medical appointments in an ambulatory setting, and requires at least five working days’ advance notice.

3. Please have the following information ready at the time of the request:
   a. Member’s name
   b. Member’s Card Identification Number
   c. Member’s gender
   d. Member’s age
   e. Date of appointment
   f. Time of appointment
   g. Language needed
   h. Approximate duration
   i. Type of visit
   j. Name of doctor/facility
   k. Address of appointment/location
   l. Phone number of appointment/location

4. If the member is in CalOptima Direct, call CalOptima’s Customer Service department at 714-246-8500. Prior authorization is not required.

5. If the member is in a health network, please use the list below to contact the member’s health network after verifying eligibility. The member’s health network will work with you and the member to coordinate all interpreter services.
<table>
<thead>
<tr>
<th>Health Network</th>
<th>Telephonic Interpreter Service Contact</th>
<th>Face-to-face Interpreter Service Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADOC Medical Group</td>
<td>844-292-5173</td>
<td>844-292-5173</td>
</tr>
<tr>
<td>Alta Med Health Services</td>
<td>877-462-2582</td>
<td>877-462-2582</td>
</tr>
<tr>
<td>AMVI Care Health Network</td>
<td>866-796-4245</td>
<td>866-796-4245</td>
</tr>
<tr>
<td>Arta Western Health Network</td>
<td>800-788-8879</td>
<td>800-788-8879</td>
</tr>
<tr>
<td></td>
<td>or via fax referral request: 949-567-0236</td>
<td>or via fax referral request: 949-567-0236</td>
</tr>
<tr>
<td></td>
<td>or via online referral request:</td>
<td>or via online referral request:</td>
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<tr>
<td></td>
<td><a href="http://www.HCP-Connect.com">www.HCP-Connect.com</a></td>
<td><a href="http://www.HCP-Connect.com">www.HCP-Connect.com</a></td>
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<tr>
<td>CHOC Health Alliance</td>
<td>800-424-2462</td>
<td>800-424-2462</td>
</tr>
<tr>
<td>Family Choice Health Network</td>
<td>Language Line: 800-874-9426</td>
<td>800-611-0111</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>800-464-4000 or</td>
<td>800-464-4000 or</td>
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<tr>
<td></td>
<td>800-777-1370 (TDD/TTY)</td>
<td>800-777-1370 (TDD/TTY)</td>
</tr>
<tr>
<td>Monarch Family HealthCare</td>
<td>888-656-7523</td>
<td>888-656-7523</td>
</tr>
<tr>
<td>Noble Mid-Orange County</td>
<td>888-880-8811</td>
<td>888-880-8811</td>
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<tr>
<td></td>
<td>Ask for Utilization Department</td>
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<tr>
<td>Prospect Medical Group</td>
<td>800-708-3230</td>
<td>800-708-3230</td>
</tr>
<tr>
<td></td>
<td>or fax request to: 714-560-7305</td>
<td>or submit request online:</td>
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<tr>
<td></td>
<td>or submit request online:</td>
<td><a href="http://www.prospectmedical.com">www.prospectmedical.com</a></td>
</tr>
<tr>
<td>Regal Medical Group</td>
<td>844-292-5173</td>
<td>844-292-5173</td>
</tr>
<tr>
<td>Talbert Medical Group</td>
<td>800-297-6249</td>
<td>800-297-6249</td>
</tr>
<tr>
<td></td>
<td>or via fax referral request: 714-436-4408</td>
<td>or via fax referral request: 714-436-4408</td>
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<td>Or via online referral request:</td>
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<td><a href="http://www.HCP-Connect.com">www.HCP-Connect.com</a></td>
<td><a href="http://www.HCP-Connect.com">www.HCP-Connect.com</a></td>
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<tr>
<td></td>
<td>Need access code for interpreter services</td>
<td></td>
</tr>
<tr>
<td>United Care Medical Network</td>
<td>877-225-6784</td>
<td>877-225-6784</td>
</tr>
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</table>
N8: TIPS FOR DOCUMENTING INTERPRETER SERVICES

Federal and state regulations require that CalOptima, its health networks, medical groups and providers offer free interpreter services to limited English proficient members. Regulations also require CalOptima to ensure that qualified interpreters are professionally trained, culturally competent, and are versed in medical terminology and managed care concepts.

Because of these requirements, it is important that practices document when members use or refuse to use qualified interpreter services. Documenting refusal of interpreter services in the member record not only protects the provider and the provider’s practice, it also ensures consistency when medical records are monitored through site reviews or audits to ensure adequacy of CalOptima’s Language Assistance program.

TIPS FOR DOCUMENTING INTERPRETER SERVICES

1. CalOptima recommends using professionally trained interpreters and documenting the use of the interpreter in the member’s medical record.

2. If the member was offered a qualified interpreter and refused the service, it is important to note that refusal in the member record for that visit.

3. Using a family member or friend to interpret should be discouraged. However, if the member insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.

4. Smart Practice Tip: Consider offering a telephonic interpreter in addition to the family member/friend to ensure accuracy of interpretation.

5. For all limited English proficient members, it is a best practice to document the member’s preferred language in paper and or electronic medical records in the manner that best fits your practice flow.*
   a. For a paper record, one way to do this is to post color stickers on the member’s chart to flag when an interpreter is needed. (For example, Orange = Spanish, Yellow = Vietnamese, Green = Russian, etc.)*

N9: Tips for Working with Interpreters

This section applies to the following CalOptima programs:
- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

N9: TIPS FOR WORKING WITH INTERPRETERS

Medical appointments that include assistance from an interpreter have different dynamics than appointments performed without assistance of an interpreter. Below are some recommended tips about how to work with interpreters.

**TIPS FOR WORKING WITH INTERPRETERS**

1. **If possible, choose an interpreter whose age, gender and background are similar to the patient.**
   A patient might be reluctant to disclose uncomfortable information, for example, in front of an interpreter of a different gender.

2. **Hold a brief meeting with the interpreter, if needed.**
   If it is your first time working with a professional interpreter, briefly meet with the interpreter first to agree on basic interpretation protocols. Let the interpreter brief the patient on the interpreter’s role.

3. **Allow enough time for the interpreted sessions.**
   Remember that an interpreted conversation requires more time. What can be said in a few words in one language may require a lengthy paraphrase in another.

4. **Read body language during face-to-face encounters.**
   Making eye contact is key to the provider-patient relationship. Arrange yourself so that you, the patient, and the interpreter are visible to one another (i.e., triangular). Watch the patient’s eyes and facial expression when you speak and when the interpreter speaks. Look for signs of comprehension, confusion, agreement or disagreement.

5. **Speak in a normal voice, clearly, and not too fast or too loudly.**
   It is usually easier for the interpreter to understand speech produced at normal speed and with normal rhythms, than artificially slow speech.

6. **Avoid jargon and technical terms.**
   Avoid idioms, technical words or cultural references that might be difficult to interpret. (Some concepts may be easy for the interpreter to understand but extremely difficult to interpret.)

7. **Talk to the patient directly, using first person. Be brief, explicit and basic.**
   Remember that you are communicating with the patient through an interpreter. Pause after a full thought for the interpretation to be accurate and complete. If you speak too long, the interpreter may not remember to include everything you say.

8. **Don’t ask or say anything that you don’t want the patient to hear.**
   Expect everything you say to be interpreted, as well as everything the patient and his or her family says.

9. **Be patient and avoid interrupting during interpretation.**
   Allow the interpreter as much time as necessary to ask questions, for repeats and for clarification. Be prepared to repeat yourself in different words if your message is not understood. Professional
interpreters do not interpret word-for-word but rather concept-by-concept. Also remember that English is a direct language and may need to be relayed in complex grammar and different communication patterns.

10. **Be sensitive to appropriate communication standards.**
Different cultures have different protocols to discuss sensitive topics and to address physicians. Many ideas common in the United States may not exist in the patient’s culture and may need detailed explanation in another language.
N10: TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT (LEP) MEMBERS

Regulations require that CalOptima, its contracted health networks, medical groups and providers offer free interpreter services to limited English proficient (LEP) members. Interpreters must be professionally trained and versed in medical terminology and health care benefits. As a result, it is important that providers know how to identify, offer and access interpreter services for LEP members.

TIPS FOR WORKING WITH LEP MEMBERS

1. **Who are considered LEP members?**
   Individuals who do not identify English as their preferred language and who have a limited ability to read, speak, write or understand English, may be considered LEP.

2. **How to identify LEP members over the phone.**
   An LEP member may exhibit the following characteristics:
   a. Is quiet or does not respond to questions
   b. Responds with a simple “yes” or “no,” or gives inappropriate or inconsistent answers to your questions
   c. May have trouble communicating in English or you may have a very difficult time understanding what he or she is trying to communicate
   d. Identifies as LEP by requesting language assistance

3. **How to offer interpreter services to an LEP member when member speaks no English and you are unable to discern the language.**
   If you are unable to identify the language spoken by the LEP member, you should request telephonic interpreter services to identify the language needed. For more information on accessing interpreter services, see Section N7: Accessing Interpreter Services.

4. **How to best communicate with an LEP member who speaks some English but with whom you are having difficulty communicating.**
   Speak slowly and clearly with the member. Do not speak loudly or shout. Use simple words and short sentences.

5. **How to offer interpreter services to the member.**
   Here are a couple of recommended ways to offer interpreter services:
   a. “I think I am having trouble explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?”
   b. “I am going to connect us with an interpreter. Which language do you speak?”

6. **Best practice to capture language preference.**
   For LEP members, it is a best practice to capture the member’s preferred language and record it in the plan or provider’s member data system. You may want to consider asking the following question:
“In order for (provider’s name) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?”
N11: CULTURAL COMPETENCY TRAINING

CalOptima regularly conducts cultural competency training seminars that are open to providers, provider office staff and health network staff. The purpose of the training is to:

1. Furnish information and education on the cultural concerns and needs of CalOptima’s member population.

2. Provide tips and resources to help enhance services provided to CalOptima members.

3. Comply with regulatory mandates.

CalOptima holds quarterly Awareness and Education Seminars at its offices located at 505 City Parkway West, Orange, CA 92868.

HOW TO SIGN UP FOR CULTURAL COMPETENCY TRAINING

To register for CalOptima’s Awareness and Education Seminars, contact CalOptima’s Customer Service department at 714-246-8500, Monday through Friday, from 8 a.m. to 5:30 p.m., or email Cultural and Linguistic Services at: culturallinguistic@caloptima.org.
O1: HEALTH EDUCATION SERVICES

Health education services are a covered benefit under CalOptima and are available to CalOptima members at no cost. CalOptima’s health education services are designed to assist and support the work of providers in promoting patient self-management and healthy behaviors.

CalOptima’s health education topics can vary by group and include, but are not limited to:

1. Tobacco Cessation
2. Fitness/Exercise
3. Weight Management
4. Nutrition
5. Diabetes
6. Depression
7. Asthma
8. COPD
9. Heart Disease
10. Cholesterol
11. Hypertension

HOW TO MAKE A HEALTH EDUCATION REFERRAL

1. If a provider would like to refer a member to CalOptima for health education services, the provider should complete the Health Education Referral Form. To obtain a copy of the Health Education Referral Form, please visit the CalOptima website, and look for forms under the Providers tab.

2. Fill out the form completely. If possible, indicate the member’s preferred language so that CalOptima’s health educators can provide services in a manner that meets the member’s cultural and linguistic needs.

3. Include the name of the referring provider and office contact information for our staff to contact you if they have questions.

Please send the completed Referral Form to CalOptima’s Health Education department by faxing to 714-338-3127 or emailing healthpromotions@caloptima.org.
HOW TO GET MORE INFORMATION ABOUT HEALTH EDUCATION SERVICES

For more information about CalOptima’s health education services, providers can:

1. Call CalOptima’s Health Education department at **714-246-8895**.

2. Contact us via email at healthpromotions@caloptima.org.

3. Visit CalOptima’s website at www.caloptima.org/healtheducation

<table>
<thead>
<tr>
<th>CalOptima Policies and Procedures:</th>
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<tr>
<td>GG.1201: Health Education Programs</td>
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</table>
O2: Referrals to the Disease Management Program

This section applies to the following CalOptima programs:

- Medi-Cal,
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

O2: REFERRALS TO THE DISEASE MANAGEMENT PROGRAM

CalOptima provides disease management programs for members with chronic diseases and conditions. These programs were developed in accordance with the Department of Health Care Services (DHCS), The Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), or any other managed care program requirements and are administered centrally by CalOptima staff.

The goal of disease management is to improve health outcomes for members by augmenting and helping support the work of its primary care providers in managing chronic conditions. Programs may address, but are not limited to, the following chronic health conditions:

- Asthma
- Congestive heart failure
- Diabetes
- Obesity
- Other chronic health conditions based on information analysis, consumer feedback or new health plan requirements

CalOptima identifies and automatically enrolls members meeting certain clinical criteria into the disease management program. Members can elect not to participate upon enrollment. All identified members receive an introductory letter informing them of their eligibility to participate in the program, along with instructions about how to opt out of the program if they so choose.

CalOptima stratifies the identified members into two risk categories based upon the severity of their condition and utilization characteristics. These risk levels determine the type of intervention that the disease management program applies:

- **High Risk** — Health coach and referral to case management, if indicated, 1:1 telephonic counseling on self-management of condition, coaching on medication adherence and lifestyle changes, monitoring of lab tests, provision of information on depression, tests and shots, and reminder letters, in addition to low risk services
- **Low Risk** — Educational mailings, disease-specific newsletter publications with articles on self-management and resources such as community classes

IDENTIFYING AND REFERRING MEMBERS WHO WOULD BENEFIT FROM DISEASE MANAGEMENT

- **How to Identify Members Who May Benefit from Disease Management** — Providers can help identify members who would likely benefit from participating in the disease management program. These are members who require adherence and maintenance to manage their chronic conditions (e.g., asthma, diabetes, etc.).

- **How to Refer a Member to Disease Management** — If a provider would like to refer a member to the disease management program:
Complete the Health Education/Disease Management Referral form in the Common Forms section of the CalOptima website (https://www.caloptima.org/Home/Providers/CommonForms.aspx) and fax it to: 714-338-3127, or email to DiseaseManagement@caloptima.org.

- **Opting Out of the Disease Management Program** — If a member would like to opt out of the disease management program, ask the member to call CalOptima’s Health Education and Disease Management department at 714-246-8895.

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<tr>
<th>CalOptima Policies and Procedures:</th>
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<tr>
<td>GG. 1209: Population-Based Care: Disease Management</td>
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</table>
P1: FRAUD, WASTE OR ABUSE — INVESTIGATING AND REPORTING

Federal and state regulations require CalOptima to work with its providers to identify and report potential cases of health care fraud, waste or abuse to law enforcement agencies. Examples of health care fraud, waste and abuse include:

1. A person using someone else’s CalOptima card
2. A member getting a bill for services covered by CalOptima
3. A member getting a bill for unnecessary services or services not performed
4. A provider submitting claims for duplicate services, unbundled services or upcoding services
5. A supply or equipment company sending a bill for something (like a wheelchair or diabetic supplies) that was not ordered by the doctor or not delivered to the member

Potential fraud, waste or abuse cases are referred to CalOptima’s Special Investigations Unit (SIU) through the following means:

1. Suspected Fraud or Abuse Referral form via email to the following email address: Fraud@CalOptima.org.
2. Compliance and Ethics Hotline (anonymous reporting) at 877-837-4417
3. Information submitted anonymously via mail to the following address:
   CalOptima SIU
   505 City Parkway West
   Orange, CA 92868
4. A First Tier, Downstream or Related Entity (FDR), health network or any other delegated entity with a contractual obligation to report suspected fraud, waste or abuse must notify CalOptima in accordance with the terms and conditions of its contract and policy HH.1105 Fraud, Waste, and Abuse Detection.

HOW TO REPORT SUSPECTED HEALTH CARE FRAUD

Suspected fraud or abuse should be reported to CalOptima immediately.

1. Complete the Suspected Fraud or Abuse Referral form and attach all supporting documents, making sure all items are clear and legible. To obtain a copy of the form, please access the Providers section of the CalOptima website.
2. Email the form and supporting documents to Fraud@CalOptima.org, OR fax the form and all supporting documents to CalOptima’s Office of Compliance at 714-481-6457.

CalOptima’s Special Investigations Unit (SIU) will investigate cases to determine if potential fraud or abuse exists, refer potential fraud and abuse cases to the appropriate entity and document the process for each case. CalOptima may coordinate an independent internal investigation with other CalOptima departments and FDRs, health networks, or any other delegated entity, including procuring the services of contracted investigators, as needed.

CalOptima will report, as appropriate, to all local, state and federal entities.

MONTHLY AND ANNUAL REQUIREMENTS

Federal and state regulations require CalOptima to ensure an FDR, health network or any other delegated entity monitors the following monthly to ensure that no individuals or entities that are excluded from participating in federal health care programs are paid by CalOptima monies:

1. The General Services Administration’s (GSA) System for Award Management (SAM) website
2. The Office of Inspector General Exclusions Database (http://exclusions.oig.hhs.gov/)
3. Medicare Exclusion Database (MED)
4. Medi-Cal’s Suspended and Ineligible (S&I) list

CalOptima requires FDRs and health networks to implement comprehensive corporate compliance programs in accordance with the Office of Inspector General’s 7 Elements of an Effective Compliance Program. For more information, organizations can refer to the OIG’s website at http://oig.hhs.gov for training and reference materials.

CalOptima requires an FDR, health network or any other delegated entity to train all their employees, board members, contractors and sub-contracted entities on the following, annually:

1. Fraud, Waste and Abuse (FWA) Training

2. Compliance Training
   a. Upon completion of the FWA training, CalOptima requires First Tier, Downstream and Related Entities (FDR), health network, or any other delegated entity to sign an Attestation for FWA Training.

CalOptima Policies and Procedures:
HH.1105: Fraud and Abuse Detection
HH.1107: Fraud, Waste and Abuse Investigation and Reporting
HH.2021: Exclusion Monitoring
HH.2023: Compliance Training
This section applies to the following CalOptima programs:

Medi-Cal, PACE, OneCare (HMO SNP),
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

P2: ABOUT HIPAA PRIVACY

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires CalOptima and its providers to protect the security and privacy of its members’ Protected Health Information (PHI) and to provide its members with certain privacy rights, including the right to file a privacy complaint.

PHI is any individually identifiable health information, including demographic information. PHI includes a member’s name, address, phone number, medical information, Social Security number, card identification number, date of birth, financial information, etc.

CalOptima supports the efforts of its providers to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, CalOptima and its providers need to work together to comply with HIPAA requirements in terms of protecting patient privacy rights, safeguarding PHI and providing patients with access to their own PHI upon request.

KEY TIPS FOR PROVIDER OFFICES

Member Rights

Under HIPAA, all patients have rights related to their PHI to which both CalOptima and providers must adhere. The Notice of Privacy Practices outlines CalOptima members’ privacy rights and CalOptima’s responsibilities. To obtain a copy of the Notice of Privacy Practices, please visit the CalOptima website. Providers should have their own Notice of Privacy Practices. Furthermore, should a CalOptima member want to exercise his or her privacy rights, you may need to request, or advise the patient about how to request, access to his or her PHI from CalOptima.

The chart below lists members’ rights with respect to their PHI. Members may exercise any of these rights with respect to PHI held by the provider and/or CalOptima. If the member intends to exercise one of those rights as it pertains to the PHI CalOptima maintains as part of its Designated Record Set (DRS), the chart also identifies the specific CalOptima request or authorization form to assist the member.

To obtain a copy of the applicable form, please visit the CalOptima website at www.caloptima.org.

<table>
<thead>
<tr>
<th>Member Right</th>
<th>CalOptima Request/Authorization Forms</th>
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<tbody>
<tr>
<td>Members can request access to or copies of their PHI, which can include claims reports, care management records or enrollment information (in paper or electronic formats) that is considered part of CalOptima's Designated Record Set (DRS)</td>
<td>Individual Request for Access to Protected Health Information (PHI)</td>
</tr>
<tr>
<td>Members can request that CalOptima change their PHI records. CalOptima does not have to agree to the request.</td>
<td>Member Request to Amend Protected Health Information (PHI)</td>
</tr>
<tr>
<td>Members can request an accounting of how their PHI was disclosed by CalOptima.</td>
<td>Request for Accounting of Disclosures</td>
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</tbody>
</table>
Members can request that CalOptima communicate with them via different modes or send mail to a different address other than their home residence.

Members can request that CalOptima restrict the use or disclosure of their PHI. CalOptima does not have to agree to the request.

Members must authorize CalOptima to use or disclose their PHI to another person or organization.

Members must authorize CalOptima to use or disclose their PHI to a family member or friend that is involved in the member’s care.

Safeguarding PHI

Both CalOptima and its providers are required by law to protect members’ PHI. The table below contains a few important reminders on how to protect and secure PHI.

<table>
<thead>
<tr>
<th>PHI</th>
<th>PHI in Paper Form</th>
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<tbody>
<tr>
<td>In the Office</td>
<td>PHI should be locked away during non-business hours.</td>
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<tr>
<td></td>
<td>PHI should not be visible to others.</td>
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<tr>
<td>Fax</td>
<td>Staff must verify fax numbers and recipients prior to sending the fax.</td>
</tr>
<tr>
<td></td>
<td>Outgoing faxes must include a fax cover sheet that contains a confidentiality statement.</td>
</tr>
<tr>
<td></td>
<td>Incoming/outgoing faxes must not be left unattended during non-business hours.</td>
</tr>
<tr>
<td>Mail</td>
<td>Quality checks of mailings (i.e., verifying the address and contents) must be conducted prior to sending.</td>
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<td></td>
<td>Envelopes or packages must be properly sealed and secured prior to sending.</td>
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<tr>
<td>Handling PHI offsite</td>
<td>PHI must be protected during transport to and from the office using binders, folders or protective covers.</td>
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<tr>
<td></td>
<td>PHI must not be left unattended in vehicles.</td>
</tr>
<tr>
<td></td>
<td>PHI must not be left unattended in baggage at any time during traveling.</td>
</tr>
<tr>
<td>Disposal</td>
<td>PHI must be shredded; never recycle anything containing PHI.</td>
</tr>
</tbody>
</table>
PHI

Email

Do not include PHI such as the individual’s name or Beneficiary ID number (CIN) in the subject line of the email.

Email that is sent to an external entity through the open internet shall not contain PHI unless the email and attachment are encrypted to prevent anyone other than the intended receiver from reading the contents.

Confirm the recipient’s address prior to sending.

Social Media

Do not post images and videos of patients without written consent. This includes photographs or images taken inside a health care facility in which a patient’s face or other PHI (e.g. white boards) are visible.

Even if names are not used, do not share information that could allow an individual to be identified.

Electronic Devices

Portable data storage devices (CDs, DVDs, USB drives, portable hard drives, etc.) must be encrypted.

Disposal

PHI in electronic form must be destroyed or disposed of in a secure manner.

PHI in Oral Form

Oral Communications

PHI must not be discussed in public areas.

If there is another person in the room, obtain the patient’s permission prior to discussing their condition.

PHI must not be discussed with an unauthorized person(s).

PHI must be discussed quietly.

Receiving Calls

Staff must verify the identification of caller.

Staff must gain/verify authorization if caller is not the member.

Staff must designate “quiet areas” for PHI exchange.

Staff must speak quietly when discussing PHI.

Making Calls

Staff must verify they are speaking with the member.

Staff must gain/verify authorization if member is not available.

Staff must designate “quiet areas” for PHI exchange.

Staff must not leave identifying information on an answering machine/voicemail.

Staff must speak quietly when discussing PHI.

Reporting a Breach of PHI

A breach is an unauthorized access, use or disclosure of Protected Health Information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that is...
reasonably believed to have been acquired by an unauthorized person. A breach may be paper, verbal or electronic.

Some examples of breaches include, but are not limited to:

1. Sending a member’s PHI to an unauthorized person(s) via fax, email or postal mail.
2. Misplacing or losing any electronic devices (e.g., thumb drive, laptop) which contain PHI.
3. Throwing PHI in the trash instead of in a shred bin.
4. Posting information about patients or pictures of patients on a social media website.

If you would like more information regarding what constitutes a breach of PHI, visit the U.S. Department of Health & Human Services’ website at www.hhs.gov/hipaa.

If a provider becomes aware that a breach of PHI has occurred affecting any CalOptima member, whether caused by CalOptima, a CalOptima health network, a delegated entity or an FDR, the provider should notify CalOptima immediately upon discovery. To report a breach to CalOptima, call 888-587-8088 and ask for the Privacy Officer, or email privacy@caloptima.org

**CalOptima Policies and Procedures:**
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
HH.3014: Use of Electronic Mail with Protected Health Information
HH.3016: Guidelines for Handling Protected Health Information Offsite
Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) plays the central role in structuring care for CalOptima members. The PCP is the main provider of health care services for CalOptima members and is responsible for the delivery of health care to his or her assigned members. CalOptima’s model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

RESPONSIBILITIES OF THE PCP

PCP responsibilities include, but are not limited to:

1. Provide care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.

2. Furnish risk assessment, treatment planning, coordination of medically necessary services, referral, follow up and monitoring of appropriate services and resources required to meet the needs of the member.

3. Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.

4. Assure access to care 24 hours a day, seven days a week, including accommodations for urgent care, performance of procedures and inpatient rounds.

5. Coordinate and direct appropriate care for members, including:
   a. Initial assessments
   b. Preventive services in accordance with established standards and periodicity schedules as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
   c. Second opinions
   d. Consultation with referral specialists
   e. Follow-up care to assess results of primary care treatment regimen and specialist recommendations
   f. Special treatment within the framework of integrated, continuous care

6. Coordinate the authorization of specialist and non-emergency hospital services for members.

7. Contact and follow up with the member when the member misses or cancels an appointment.

8. Record and document information in the member’s medical record, including:
   a. Member office visits, emergency visits and hospital admissions
   b. Problem lists, including allergies, medications, immunizations, surgeries, procedures and visits
   c. Efforts to contact the member
   d. Treatment, referral and consultation reports
   e. Lab and radiology results ordered by the PCP
9. A physician must countersign and date a sample of, at minimum, five percent (5%) of the medical records within thirty (30) calendar days of the date of treatment by the PA, NP, CNP. For services rendered by a CNM, a physician countersignature is not required.

10. A physician must review, countersign, and date any Schedule II drugs ordered by the PA, within seven (7) calendar days. When Schedule II drugs are furnished by an NP, CNP, and/or CNM a countersignature by a physician is not required. The NP, CNP and/or CNM shall adhere to the provisions of their standardized procedures when furnishing Schedule II drugs to address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

11. Make reasonable attempts to communicate with the member in the member’s preferred language, using available interpretation or translation services.

12. If the member has a behavioral health diagnosis, coordinate the member’s care with the member’s behavioral health provider or behavioral health case manager.

**CalOptima Policies and Procedures:**

GG.1110: Primary Care Practitioner Definition, Role and Responsibilities
Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) is the main provider of health care services for OneCare and OneCare Connect members and is responsible for the delivery of health care to his or her assigned members. OneCare and OneCare Connect’s model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

RESPONSIBILITIES OF THE PCP

PCP responsibilities include, but are not limited to:

1. Furnish appropriate care for the health care problems presented by a member, including preventive, acute and chronic health care, and provide referrals to other practitioners for services.

2. Provide risk assessment, treatment planning, coordination of medically necessary services, referral, follow up, and monitoring of appropriate services and resources required to meet a member’s health care needs. Coordinate medically necessary services that are available to OneCare and OneCare Connect members as part of their dual eligibility.

3. Provide basic medical case management to assigned members:
   a. Ensure continuity of care for the member and an interactive relationship between the PCP and the member.
   b. Initiate and maintain in the medical record an individualized care plan (ICP) that addresses areas identified through the comprehensive assessment.
      i. The PCP participates on the members’ Interdisciplinary Care Team (ICT), which assesses the members’ needs and works together on the ICP.
   c. Communicate the ICP with providers involved in the member’s care at the point of notification of a planned or unplanned transition of care.
   d. Increase member satisfaction.
   e. Facilitate access to appropriate health services.
   f. Ensure appropriate use of specialty and hospital services.
   g. Ensure the appropriate use of the pharmacy and drug benefit, including medication reconciliation.
   h. Screen health status, monitor and provide preventive health services.
   i. Identify and provide appropriate health education to improve a member’s understanding of the importance of a healthy lifestyle and disease-specific interventions.

4. Assure the provision of the required scope of services to the assigned members.

5. Verify eligibility of the member at the time services are provided.

6. Assure access to care 24 hour a day, seven days a week, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency and back-up coverage in the PCP’s absence.
Q1: Role of the Primary Care Provider (PCP)

7. Keep office waiting times to a maximum of 45 minutes.

8. Coordinate and direct appropriate care for members, including:
   a. Review of the comprehensive Health Risk Assessment (HRA) that is completed within 90 calendar days after enrollment in OneCare or OneCare Connect, and schedule an appointment for high risk members within 30 calendar days.
   b. Provide preventive services in accordance with established standards and periodicity schedules, as required by age and according to the United States Preventive Services Task Force (USPSTF), the American College of Physicians (ACP), the American Academy of Family Medicine (AAFM), and relevant indicators of deficits.
   c. Provide second opinions as necessary.
   d. Consult with referral specialists (including providing necessary history and clinical data to assist the specialists with their examination of the member).
   e. Provide follow-up care to assess results of the primary care treatment regimen and specialist recommendations.
   f. Provide special treatment within the framework of integrated, continuous care.

9. Coordinate the authorization of specialist and non-emergency hospital services for a member and ensure that services generated from referrals are initiated within 30 calendar days after the visit at which the referral was made.

10. Assure the provision of basic clinical services including primary evaluation and treatment of acute and chronic medical and surgical problems in all systems.

11. Record the following information in the medical record and make records available for review upon request by OneCare, the member’s health network, and applicable federal and state oversight agencies:
    a. Member office visits, emergency visits and hospital admissions
    b. A problem list that includes allergies, medications, immunizations, surgeries, procedures and visits
    c. Efforts to contact a member
    d. Treatment, referral, consultation and inpatient stay reports
    e. Laboratory and radiology results ordered by the PCP
    f. Individualized Care Plan (ICP)

12. Adhere to the following to ensure that the member’s medical record documentation is accurate:
    a. The documentation of each encounter includes the reason for encounter and relevant history, physical examination findings, and prior diagnostic test results, assessment, clinical impression, or diagnosis, medical plan of care, date and legible identity of the rendering provider.
    b. The current procedural terminology (CPT) and current International Classification of Diseases (ICD) codes reported on the health insurance claim form or billing statement supported by the documentation in the medical record

13. Countersign and date a sample of, at minimum, five percent (5%) of the medical records within thirty (30) calendar days of the date of treatment by the PA, NP, CNP. For services rendered by a CNM, a physician countersignature is not required.

14. Review, countersign, and date any Schedule II drugs ordered by the PA, within seven (7) calendar days. When Schedule II drugs are furnished by an NP, CNP, and/or CNM a countersignature by a physician is not required. The NP, CNP and/or CNM shall adhere to the provisions of their standardized procedures when
furnishing Schedule II drugs to address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

15. Facilitate and ensure quality of care by establishing procedures to contact a member when the member misses an appointment that requires rescheduling for additional visits and following up on referrals to a specialist for care.

16. Assist the member with the OneCare or OneCare Connect grievance and appeals processes as set forth in CalOptima policies. (Please reference applicable policies below.)

17. Coordinate the transfer of the member and his or her medical records to another provider upon notification of a planned or unplanned transition of care episode, or upon request by the member, the member’s health network or OneCare or OneCare Connect.

18. Make all reasonable attempts to communicate with a member in the member’s preferred language, using interpretation or translation services available through a member’s health network.

19. Preserve the dignity of the member.

CalOptima Policies and Procedures:
MA.5010: PCP Definition, Role and Responsibility
MA.9001: Complaint Process
MA.9002: Member Grievance Process
MA.9003: Standard Service Appeal
MA.9004: Expedited Service Appeal
MA.9005: Payment Appeal
MA.9006: Provider Grievance Process
MA.9007: Appeal Process for Member Discharge from Inpatient Facility
MA.9008: Appeal Process for Coverage Termination of SNF, Home Health, or CORF services Payment
Q2: MEMBER MEDICAL RECORD

CalOptima is responsible for ensuring that a complete medical record is maintained for each member that reflects all aspects of the member’s care. CalOptima shall monitor a provider’s compliance with maintaining a member’s medical record during a full scope facility site review. CalOptima shall maintain confidentiality of the member’s medical information in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy and HIPAA security policies and additional applicable state and federal laws. Upon request, providers shall provide a member access who wishes to view his or her medical records.

ORGANIZATION OF MEDICAL RECORDS

Each provider shall designate an individual responsible for the medical record system by which the site collects, processes, maintains, stores, retrieves, identifies and distributes clinical information.

Active Records

- A provider shall label and file all active records in a defined system to facilitate the retrieval of a record on demand.

- A provider shall store active records in a secured area that protects the records from loss, tampering, alteration or destruction.

Inactive Records

- A provider may store inactive records in electronic or hard copy format.

- A provider shall maintain an inactive record through the following process:
  a. For an adult member, for seven years from the last date of service
  b. For a member who is a minor, inactive records shall be stored for at least one year after the 18th birthday, but in no event for less than seven years from the last date of service.

- For OneCare Connect members, providers shall retain active records:
  a. For 10 years after the last date of service for an adult member
  b. For 10 years after a minor member’s 21st birthday

Filing of Information

- A provider shall file all documents chronologically within the record, with the member’s name and the name of the provider on each document.

- All reports shall be filed in the medical record within 48 hours after receipt, with physician signature and date of review including, but not limited to:
  a. Laboratory reports
  b. X-ray reports
  c. Electroencephalograms (EEGs)
  d. Echocardiograms (EKGs)
  e. Consultation reports
Member’s Medical Record

- CalOptima shall ensure that a complete medical record is maintained for each member that reflects all aspects of patient care, including ancillary services and, at a minimum, includes:
  a. Member identification on each page; personal/biographical data in the record
  b. Initial Health Assessment within 120 days of enrollment in accordance with Medi-Cal Managed Care Division (MMCD) Policy Letter 08-003
  c. Member’s preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services
  d. All entries dated and author identified; for member visits, the entries shall include, at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan
  e. The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered
  f. Allergies and adverse reactions are prominently noted in the record
  g. All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable
  h. Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions
  i. Consultations, referrals, specialists, pathology and laboratory reports. Any abnormal results shall have an explicit notation in the record
  j. For medical records of adults, documentation of whether the individual has been offered information or has executed an advance directive such as a durable power of attorney for health care
  k. Health education behavioral assessment and referrals to health education services

OneCare and OneCare Connect Members’ Medical Record

- A provider shall establish an individual record for each member and shall update the record during each visit or encounter.
- The record shall be available in a legible handwritten or typed format.
- The record shall reflect the findings of each visit or encounter including, but not limited to:
  a. Recording date of service
  b. Chief complaint
  c. Follow up from previous visits
  d. Test or therapies ordered
  e. Diagnosis or medical impression
  f. Any physical, psychosocial or educational needs identified during the encounter

- A provider shall include the following data sets in each medical record:
  a. The member’s demographic information including, but not limited to, the member’s:
     i. Name and address
     ii. Age and birth date
     iii. Sex
     iv. Telephone number
     v. Emergency contact person and nearest relative (phone number for each)
     vi. Social Security number
     vii. OneCare identification card
     viii. Health insurance claim (HIC) number
  b. Clinical related data that includes:
i. Record of diagnosis and treatment
ii. Drug orders
iii. Vital signs including:
   • Height
   • Weight
   • Temperature
   • Pulse and respirations
   • Blood pressure for members over three years of age
iv. Signature and title of person performing vital signs
v. Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record problem list maintained with current updates
vi. List of medications maintained with current updates including:
   • Name
   • Strength
   • Dosage
   • Route (if other than oral)
   • Frequency
vii. Ancillary services
viii. Medical and surgical histories including relevant family history for:
   • Significant health problems
   • Reaction to medications
   • Personal habits such as use of alcohol, use of drugs and diet
ix. Physical examination by body systems with findings and treatment plan when medically indicated. A provider may use subjective, objective, assessment, plan (SOAP) format
x. Records related to all hospitalizations such as:
   • History and physical (H&P)
   • Discharge summary
   • Operative reports
   • Pathology reports
xi. Office laboratory, surgical, or invasive procedures including anesthetics used and specimens collected for pathological examination
xii. Records related to an emergency room encounter reflecting:
   • Assessment
   • Treatment
   • Discharge instructions
   • Recommended follow up
xiii. Signed consent form or statement for any invasive procedure
xiv. Authorization forms
xv. Significant telephone advice documented with date, time and signature
xvi. Consultation reports

Preventive Care

- Member education and referrals to health education services shall be documented including, but not limited to:
  a. Information provided on periodic exams
  b. Stool guaiac
  c. Sigmoidoscopy
  d. Colonoscopy
  e. Pelvic/pap smear
Q2: Member Medical Record

f. Mammogram

g. Instructions on breast self-exam

h. Nutrition

i. Accident prevention

j. Preventive care and health maintenance services rendered

k. A complete record of immunizations

Authentication of Medical Record Entries

Medical record entries shall be dated and signed by each staff person or provider at each encounter. The signature shall consist of at least the first initial, last name and title of the person making the entry.

Process for No-Show Members

When a member does not keep an appointment, the provider shall document the following in the member’s medical record:

- All attempts to reach the member.

- Instructions given to the member when contact is made, advising the member of the need to obtain medically necessary care and the risks of not keeping the appointment.

Confidentiality of Records

- All member records shall be handled with strict confidentiality.

- The medical records department manager or office manager shall be responsible for maintaining, monitoring and enforcing staff compliance in keeping member information confidential, and in the release of the member’s information when requested by the member, or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records and CalOptima HIPAA privacy policies.

- Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements.

Monitoring and Evaluation

- CalOptima shall evaluate the provider’s compliance with these guidelines through the full-scope site review, as set forth in CalOptima Policy GG.1608: Full Scope Site Reviews.

MEMBER REQUEST FOR MEDICAL RECORDS

A member shall have the right to inspect or copy his or her protected health information (PHI) in a designated record set, upon verbal request, unless the provider specifically requires a written request. Providers shall provide access to information for as long as they keep such records. Provider shall furnish to another treating or consulting provider, at no cost to the member, a copy of the member’s medical record under the following circumstances:

- If the record is necessary to facilitate the continuity of care

- If the provider is transferring the member to another provider for medical care
Q2: Member Medical Record

If the member is obtaining a second opinion

A provider shall not withhold a member’s medical records, or summaries of such records, due to unpaid bills for health care services. CalOptima and its health networks shall sanction any provider who willfully withholds member medical records because of an unpaid bill for health care services, pursuant to California Health and Safety Code, Section 123100. A provider shall provide a member access to inspect or obtain a copy of medical records within the following time frames:

- Within five business days after receiving a member’s written request
- Within 10 business days after receiving a member’s request for a summary
- Within 30 days after receiving a member’s request, if the provider notifies the member of the delay due to the length of the record or because the member was discharged from a hospital within 10 days prior to the request

A member, or member’s authorized representative may obtain copies of all, or any portion of, the member’s medical record that the member has a right to inspect:

- Upon presenting a written request for a copy of records by the member.
- Upon presenting a fee to defray the cost of copying the records that shall not exceed 25 cents ($0.25) per page or 50 cents ($0.50) for records copied from microfilm.

A provider shall not limit a member to a single request for medical records. However, the member or member’s authorized representative may obtain no more than one copy of any relevant portion of the member’s medical records free of charge.

For the purposes of utilization management, quality improvement, and other CalOptima administrative processes, CalOptima shall have access to, and copies of medical records relating to the provision of health care services to Members, provided at no charge to CalOptima.

<table>
<thead>
<tr>
<th>CalOptima Policies and Procedures:</th>
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<tbody>
<tr>
<td>GG.1603: Medical Records Maintenance</td>
</tr>
<tr>
<td>GG.1608: Full Scope Site Reviews</td>
</tr>
<tr>
<td>GG.1618: Member Request for Medical Records</td>
</tr>
<tr>
<td>MA.9201: Medical Records Maintenance</td>
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</table>
This section applies to the following CalOptima programs:

**Medi-Cal, OneCare (HMO SNP),**

**OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)**

**R1: PROVIDER COMPLAINT PROCESS**

Medi-Cal, OneCare (HMO SNP) and OneCare Connect maintains a provider complaint process to review and resolve provider disputes for claims payment, as well as utilization management decisions and other non-payment related issues.

There are two levels in the provider complaint process:

1. **Level 1** complaints involve disputes related to decisions or actions taken by a CalOptima health network, or a third party administrator (TPA) disputes of utilization management decisions, or claims payment decisions by CalOptima. Depending upon the situation, Level 1 complaints are filed with either the CalOptima health network, a third party administrator (TPA) or with CalOptima directly.

2. **Level 2** complaints are disputes of CalOptima health network or a third party administrator (TPA) Level 1 decisions or disputes of Level 1 decisions issued by the Utilization Management or Claims departments.

**Hearing for Limited Disputes**

Providers who have received a complaint resolution letter from CalOptima, a health network, or a third party administrator (TPA), have a right to a hearing if the provider disputes:

a. Recoupment of funds based upon audit findings or overpayment
b. The impositions of sanctions or penalties
c. Suspension or termination of the provider’s participation in CalOptima, a health network or a TPA

**Legal Claims and Judicial Review**

For more information, please see **Section R8: Legal Claims and Judicial Review**.

The provider complaint process contains different procedures, depending upon whether the provider filing the complaint is a Medi-Cal, OneCare or a OneCare Connect contracted provider or a non-contracted provider.

**FILING A PROVIDER COMPLAINT**

If you have a contract with a Medi-Cal, OneCare or a OneCare Connect health network, or have a contract directly with CalOptima, follow the instructions under Contracted Providers below. If you do not have a contract with a Medi-Cal, OneCare or a OneCare Connect health network or with CalOptima directly, follow the instruction under Non-Contracted Providers.

**Contracted Providers**

1. **Level 1** — To file a Level 1 complaint, please complete a Provider Dispute Resolution Request form. To obtain a copy of the Provider Dispute Resolution Request form, visit the Providers section of the CalOptima website. Please see **Section R3: Required Documentation for Complaints** for tips on how to complete the form.
2. **If the complaint involves a payment or decision rendered by a CalOptima health network**, submit the Provider Dispute Resolution Request form to the CalOptima health network. For health network contact information, see **Section B1: CalOptima Department and Program Contact Information**.

If the complaint involves a **payment or decision rendered by CalOptima directly**, submit the Provider Dispute Resolution Request form to the CalOptima Claims department. For more information on filing addresses, see **Section R4: Addresses for Filing Provider Complaints**.

3. **Level 2** — If you are not satisfied with the outcome of the Level 1 complaint, you can file a Level 2 complaint with CalOptima’s Grievance and Appeals department. To file a Level 2 complaint, you must submit a request for review in writing within 180 calendar days of receiving a complaint resolution letter. For more information on filing addresses, see **Section R4: Addresses for Filing Provider Complaints**.

**Non-Contracted Providers**

1. To file a Level 1 complaint, non-contracted providers should complete a Provider Dispute Resolution Request form. To obtain a copy of the Provider Dispute Resolution Request form, visit the Providers section of the CalOptima website. See **Section R3: Required Documentation for Complaints** for tips on how to complete the form.

2. The complaint should be filed with the entity that issued the payment (or notice of non-payment).
   a. **If a CalOptima health network issued the payment**, file the complaint with the applicable CalOptima health network. For CalOptima health network contact information, see **Section B1: CalOptima Department and Program Contact Information**.
   b. **If the complaint involves payment from CalOptima**, please submit the form to:
      
      CalOptima OneCare or OneCare Connect
      Claims Provider Dispute
      P.O. Box 11065
      Orange, CA 92856
      
      Claims Provider Dispute Resolution (Medi-Cal)
      P.O. Box 11037
      Orange, CA 92856
      
   c. **If the complaint is not claims-related**, submit the form to CalOptima’s Grievance and Appeals department. For information on where to submit the form, see **Section R4: Addresses for Filing Provider Complaints**.

3. **Level 2 Payment Related** — If you are not satisfied with the outcome of the Level 1 complaint, you can file a Level 2 complaint with CalOptima’s Grievance and Appeals department.

4. **Zero Payment Appeal (OneCare or OneCare Connect)** — You can file an appeal with CalOptima’s Grievance and Appeals department within 60 calendar days of the notice of non-payment. CalOptima’s Grievance and Appeals department will process your appeal if you submit a signed Waiver of Liability form. The Waiver of Liability form indicates that you will not bill the member regardless of the appeal decision. To obtain a copy of the Waiver of Liability form, please visit the Providers section of the CalOptima website. If the decision is not wholly in your favor, CalOptima’s Grievance and Appeals department will forward your case file to the Medicare Independent Review Entity.
5. **If you did not submit a signed waiver** — CalOptima’s Grievance and Appeals will dismiss your appeal.

6. **Level 2 Non Payment Related** — If the complaint is **not payment related**, you should file your complaint with CalOptima’s Grievance and Appeals department.

7. **Medicare Independent Review Entity (OneCare or OneCare Connect)** — CalOptima’s Grievance and Appeals department will automatically submit the Level 2 appeal to the Medicare Independent Review Entity (IRE) if the appeal is not resolved wholly in favor of the non-contracted provider.

8. **Administrative Law Judge Hearing (OneCare or OneCare Connect)** — If the non-contracted provider is not satisfied with the Medicare IRE Level 2 decision, the provider may file a Level 3 appeal with an Administrative Law Judge (ALJ). The appeal must be filed within 60 days of the decision issued by the Medicare IRE, and the amount in dispute must meet the threshold amount specified by Medicare. The ALJ must issue a decision within 90 days of receipt and acceptance of the dispute appeal. Complete instructions for filing the appeal are included in the IRE decision letter to the provider.

9. **Medicare Appeals Council (OneCare or OneCare Connect)** — If the non-contracted provider is not satisfied with the ALJ Hearing Level 3 decision, the provider may request a Medicare Appeals Council (MAC) review of the ALJ decision or dismissal. The appeal must be submitted within 60 days of the ALJ hearing decision or dismissal. Complete instructions for filing the appeal are included in the ALJ decision letter.

10. **Judicial Review (OneCare or OneCare Connect)** — The provider may request a judicial review of the Medicare Appeals Council decision if the amount in dispute meets the threshold amount specified by Medicare. Complete instructions for filing the appeal are included in the MAC Appeals Council decision letter.

### MEDI-CAL PROVIDER CLAIMS PROCESS: CLAIMS AND NON-CLAIMS ISSUES

<table>
<thead>
<tr>
<th>Claims and Non-Claims Issues</th>
<th>Options Available to the Provider</th>
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</thead>
<tbody>
<tr>
<td>Contracted/Non-Contracted Provider</td>
<td>File Level 1 Provider Dispute Resolution Request with health network or CalOptima Claims department. File Level 2 Provider Dispute Resolution Request with CalOptima’s Grievance and Appeals department. Legal claims and judicial review may be available. See CalOptima Policy AA.1217: Legal Claims and Judicial Review</td>
</tr>
</tbody>
</table>

**CalOptima Policies and Procedures:**

HH.1101: Provider Complaint Process

### ONECARE AND ONECARE CONNECT PROVIDER CLAIMS PROCESS: CLAIMS AND NON-CLAIMS ISSUES

<table>
<thead>
<tr>
<th>Claims and Non-Claims Issues</th>
<th>Options Available to the Provider</th>
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<tbody>
<tr>
<td>Contracted Provider</td>
<td>File Level 1 Provider Dispute Resolution Request with health network or</td>
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## Claims and Non-Claims Issues

<table>
<thead>
<tr>
<th>Options Available to the Provider</th>
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<tbody>
<tr>
<td>CalOptima Claims department.</td>
</tr>
<tr>
<td>File Level 2 Provider Dispute Resolution Request with CalOptima’s Grievance and Appeals department.</td>
</tr>
<tr>
<td>Legal claims and judicial review may be available. See CalOptima Policy AA.1217: Legal Claims and Judicial Review</td>
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### Non-Contracted Providers

<table>
<thead>
<tr>
<th>Payment Issued — Dispute rate or service (payment for different service than service billed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• File Level 1 Provider Dispute Resolution Request with entity that issued payment (health network or CalOptima).</td>
</tr>
<tr>
<td>The health network or CalOptima notifies provider of the decision. Provider may appeal decision by filing with Grievance and Appeals.</td>
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</tbody>
</table>

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<tr>
<th>Denial — ZERO payment issued</th>
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</thead>
<tbody>
<tr>
<td>• File Level 1 Appeal with Grievance and Appeals.</td>
</tr>
<tr>
<td>• No signed waiver — Appeal will be dismissed.</td>
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</table>

<table>
<thead>
<tr>
<th>Decision not wholly in favor of provider</th>
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<tbody>
<tr>
<td>• Grievance and Appeals forwards to Independent Review Entity for external review.</td>
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</table>

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<tr>
<th>Decision not wholly in favor of provider</th>
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<tr>
<td>• File Level 3 Appeal with an Administrative Law Judge Hearing.</td>
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</table>

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<tr>
<th>Decision not wholly in favor of provider</th>
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<tbody>
<tr>
<td>• File Level 4 Appeal with the Medicare Appeals Council.</td>
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<tr>
<th>Decision not wholly in favor of provider</th>
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<tbody>
<tr>
<td>• File Level 5 Appeal with the Judicial Review.</td>
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**CalOptima Policies and Procedures:**

MA.9006: Provider Complaint Process

MA.9009: Non-Contracted Provider Payment Disputes

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Section R: Provider Complaint Process
R2: TIME LIMITS FOR FILING

The applicable time limits for filing a provider complaint vary for contracted versus non-contracted providers.

1. **Contracted Providers** — Providers who are contracted with OneCare (HMO SNP) or OneCare (HMO SNP) health networks are not covered under the Medicare appeals process. See Table 1 below.

2. **Non-Contracted Providers** — All time limits for filing a complaint for non-contracted providers are set by Medicare regulations. See Table 2 below.

It is important for providers to be aware of these filing time frames, since complaints filed outside of these time frames will not be considered.

UNDERSTANDING THE TIME FRAMES

Providers who are contracted with OneCare or with a OneCare health network should adhere to the time frames below in Table 1.

### TABLE 1: CONTRACTED PROVIDERS’ COMPLAINT SUBMISSION TIME FRAMES

#### Level 1 Provider Dispute

<table>
<thead>
<tr>
<th>Type of Dispute</th>
<th>Days to File</th>
<th>Reviewing Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong> — Pre-service Utilization Management (UM) appeal on behalf of member</td>
<td>60 calendar days from the date of the Notice of Denial</td>
<td>OneCare Grievance and Appeals department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All pre-service appeals are processed under the member appeal process.</td>
</tr>
<tr>
<td><strong>Level 1</strong> — Post Service Utilization Management (UM) appeal</td>
<td>60 calendar days from the date of the Notice of Denial</td>
<td>Entity that issued the Notice of Denial</td>
</tr>
<tr>
<td><strong>Level 1</strong> — Provider Dispute Resolution complaint</td>
<td>365 calendar days from date of the remittance advice (RA)</td>
<td>Entity that issued the payment or RA</td>
</tr>
</tbody>
</table>

#### Level 2 Provider Dispute

<table>
<thead>
<tr>
<th>Type of Dispute</th>
<th>Days to File</th>
<th>Reviewing Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 2</strong> — Disputing Level 1 decision related to medical necessity by a physician medical group or OneCare</td>
<td>60 calendar days from the date of the Level 1 decision issued by OneCare or OneCare health network</td>
<td>OneCare Grievance and Appeals department</td>
</tr>
</tbody>
</table>
R2: Time Limits for Filing

Section R: Provider Complaint Process

<table>
<thead>
<tr>
<th>Type of Dispute</th>
<th>Days to File</th>
<th>Reviewing Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2 — All other Level 1 decisions</td>
<td>180 calendar days from the date of the Level 1 decision issued by OneCare or OneCare health network</td>
<td>OneCare Grievance and Appeals department</td>
</tr>
</tbody>
</table>

All non-contracted providers should adhere to the filing time frames contained in Table 2 below:

**TABLE 2: NON-CONTRACTED PROVIDERS’ COMPLAINT SUBMISSION TIME FRAMES**

**Level 1 Provider Dispute**

<table>
<thead>
<tr>
<th>Type of Dispute</th>
<th>Days to File</th>
<th>Reviewing Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 — Pre-service Utilization Management (UM) appeal on behalf of member</td>
<td>60 calendar days from the date of the Notice of Denial</td>
<td>OneCare Grievance and Appeals department</td>
</tr>
<tr>
<td>All pre-service appeals are processed under the member appeal process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 1 – Post service Utilization Management (UM) appeal</td>
<td>60 calendar days from the date of the Notice of Denial</td>
<td>Entity that issued the Notice of Denial</td>
</tr>
<tr>
<td>Level 1 Provider Dispute Resolution Request — Disputing level of payment or claim paid for different code than billed</td>
<td>180 calendar days from date of the receipt of the notice or remittance advice in dispute</td>
<td>Entity that issued the payment or decision — OneCare health network or OneCare</td>
</tr>
<tr>
<td>Level 1 Provider Dispute Resolution Request — Disputing zero payment on a claim (must submit signed Waiver of Liability form)</td>
<td>60 days from the date of the receipt of the notice or remittance advice</td>
<td>OneCare Grievance and Appeals department. <strong>Note:</strong> CalOptima Grievance and will automatically submit the Level 2 appeal to Medicare Independent Review Entity if the appeal is not resolved wholly in favor of the non-contracted provider.</td>
</tr>
</tbody>
</table>

**Level 2 Provider Dispute**

<table>
<thead>
<tr>
<th>Type of Dispute</th>
<th>Days to File</th>
<th>Reviewing Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2 — Disputing level of payment or payment for different code than billed</td>
<td>180 days from the date of the Level 1 Provider Dispute Resolution request decision issued by OneCare or OneCare health network.</td>
<td>OneCare Grievance and Appeals department</td>
</tr>
<tr>
<td>CalOptima Policies and Procedures:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA.9001: Complaint Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA.9005: Payment Appeals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA.9006: Provider Grievance Process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
R3: REQUIRED DOCUMENTATION FOR COMPLAINTS

When filing a provider complaint, it is critical that the provider include complete documentation to support the provider’s position. Furthermore, all supporting information must be submitted within the applicable filing time frame. For more information on filing time frames, see Section R2: Time Limits for Filing. Under Medicare regulations, non-contacted providers are required to submit a signed Waiver of Liability form when appealing a zero payment denial before the appeal can be processed.

TIPS FOR DOCUMENTATION

1. **Provider Dispute Resolution Request Form — Level 2** — To submit a complaint regarding CalOptima or a health network’s response to a provider’s Provider Dispute Resolution (PDR) Level 1 submission, the provider should complete a PDR Request — Level II form. To obtain a copy of this form, visit the Providers section of the CalOptima website.

2. **Written Documentation** — When submitting a PDR form or a letter, remember to include the following information:
   a. Provider name and Provider Identification Number
   b. Contact information
   c. Copy of clean claim or authorization request, when applicable
   d. Patient’s name, when applicable
   e. Date of service, when applicable
   f. The original claim identification number, when applicable
   g. Copy of remittance advice (RA), Level 1 PDR response or denial notices, when applicable
   h. Clear identification of the disputed item
   i. Clear explanation of the issue the provider believes to be incorrect, including supporting medical records, contract or other documentation that supports the appeal or grievance

3. **Incomplete Information** — Claims disputes submitted with incomplete information will be returned to the provider clearly identifying the missing information that is necessary for the review and resolution of the dispute. The provider has 30 working days after the receipt of a returned provider dispute/complaint to resubmit the dispute with the additional information. If the information is not submitted, or not submitted timely, the dispute is closed without further action.

4. **Resolution** — All provider complaints are resolved within 45 working days from the date of receipt of the complaint or amended complaint, and a written notice of the decision is issued to the provider.

CalOptima Policies and Procedures:
HH.1101: CalOptima Provider Complaint
MA.9001: Complaint Process
MA.9005: Payment Appeals
MA.9006: Provider Grievance Process
This section applies to the following CalOptima programs:
- Medi-Cal
- OneCare (HMO SNP)
- OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

**R4: ADDRESSES FOR PROVIDER COMPLAINTS**

All provider complaints must be submitted in writing to the responsible entity within the required timelines. For more information on provider complaint filing time limits, see **Section R2: Time Limits for Filing**.

This section provides addresses for filing specific CalOptima provider complaints. Note that where you file your complaint depends upon whether:

1. You are contracted with CalOptima or a CalOptima health network.
2. The complaint is related to a decision made by CalOptima or a CalOptima health network.
3. The complaint is a Level 1 (initial complaint) or Level 2 (appeal) request.

To assist your patients in filing a member complaint, refer them to OneCare (HMO SNP) Customer Service at 877-412-2734 or OneCare Connect Customer Service at 855-705-8823 or Medi-Cal Customer Service at 888-587-8088, or you can provide them with an Appeals and Grievance form. To obtain a copy of this form, please access the Providers section of the CalOptima website.

**WHERE TO FILE A COMPLAINT**

1. **Level 1 Complaints** — Use the table below to identify where to send Provider Disputes

<table>
<thead>
<tr>
<th>Level of Dispute</th>
<th>Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1 Provider Disputes</strong></td>
<td>Send to applicable CalOptima health network</td>
</tr>
<tr>
<td>CalOptima health network claim and non-claim disputes related to decisions rendered by CalOptima health networks</td>
<td>See <strong>Section B1: CalOptima Department and Program Contact Information</strong></td>
</tr>
<tr>
<td><strong>Level 1 Provider Disputes</strong></td>
<td>CalOptima (OneCare (HMO SNP) or OneCare Connect)</td>
</tr>
<tr>
<td>CalOptima claim and non-claim disputes related to decisions rendered by CalOptima</td>
<td>Attention: Claims Provider Dispute</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 11065</td>
</tr>
<tr>
<td></td>
<td>Orange, CA 92856</td>
</tr>
<tr>
<td></td>
<td>CalOptima (Medi-Cal)</td>
</tr>
<tr>
<td></td>
<td>Attention: Claims Provider Dispute</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 11037</td>
</tr>
<tr>
<td></td>
<td>Orange, CA 92856</td>
</tr>
<tr>
<td><strong>Level 1 Non-Contracted Provider Appeal</strong></td>
<td>CalOptima</td>
</tr>
<tr>
<td>Non-payment of claim for Medicare covered services</td>
<td>Attention: Grievance and Appeals</td>
</tr>
<tr>
<td></td>
<td>505 City Parkway West</td>
</tr>
<tr>
<td></td>
<td>Orange, CA 92868</td>
</tr>
</tbody>
</table>
## Addresses for Provider Complaints

<table>
<thead>
<tr>
<th>Level of Dispute</th>
<th>Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1 and Level 2 Provider UM Appeals</strong>&lt;br&gt;Post-service disputes for decisions made by CalOptima Utilization Management</td>
<td>CalOptima&lt;br&gt;Attention: Grievance and Appeals&lt;br&gt;505 City Parkway West&lt;br&gt;Orange, CA 92868</td>
</tr>
</tbody>
</table>

2. **Level 2 — Contracted Providers**  
   Disputes related to a CalOptima health network Provider Dispute Resolution Request or CalOptima Claims Department Provider Dispute Resolution Request decisions, or other non-claim issues not resolved at the health network level should be sent to:

   CalOptima<br>Attention: Grievance and Appeals<br>505 City Parkway West<br>Orange, CA 92868

3. **Level 2 — Non-Contracted Providers**  
   **A Level 2 Provider Dispute Resolution Request related to claim payment amounts:** A provider may file a Level 2 dispute after getting a resolution decision from a Level 1 appeal or after 30 days from date the Level 1 appeal was submitted and the provider has not received a response from the health network or CalOptima Claims department at the following address:

   CalOptima<br>Attention: Grievance and Appeals<br>505 City Parkway West<br>Orange, CA 92868<br>Fax: **714-246-8562**

   **A Level 2 Provider Dispute Resolution Request related to a zero payment:** Grievance and Appeals will forward your appeal case to the Medicare Independent Review Entity, Maximus Federal Services, Inc., for a second review (if signed waiver of liability is submitted with the provider appeal) if the denial is upheld, or a decision is not rendered in 60 days. If a waiver of liability is not included or appeal is filed after 60 days and a good cause for filing a late appeal is not provided, Grievance and Appeals will dismiss the appeal.

   A resolution letter will be sent to the provider by Grievance and Appeals informing the provider of the outcome at the time of the decision and or when the case is forwarded to Maximus. Maximus will send the provider their decision within 60 days of receipt of the case.

### CalOptima Policies and Procedures:

- MA.9006: Provider Complaint Process
- HH.1101: CalOptima Provider Complaint
- MA.9009: Non Contracted Provider Payment Disputes
- GG.1510: Appeal Process for Decisions Regarding Care and Services
R5: TIME FRAME FOR RESOLUTION OF COMPLAINTS — NON-CONTRACTED PROVIDERS

Complaint resolution time frames for providers who are contracted with a OneCare (HMO SNP) or OneCare Connect health network are set as part of the health network’s contract with the provider. Check with your OneCare (HMO SNP) or OneCare Connect health network for specific information about the group’s complaint resolution time frames.

Resolution timelines for complaints submitted by non-contracted providers are set by Medicare requirements.

RESOLUTION TIME FRAMES FOR NON-CONTRACTED PROVIDERS

Please use the table below to find the applicable resolution time frames by type of non-contracted provider complaints:

<table>
<thead>
<tr>
<th>Type of Non-Contracted Provider Complaint</th>
<th>Days</th>
<th>Review Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 Provider Dispute Resolution Request — Payment amount in dispute</td>
<td>30 calendar days</td>
<td>Entity (health network or CalOptima) that issued the payment in dispute</td>
</tr>
<tr>
<td>Level 2 Provider Dispute Resolution Request — Payment Amount in Dispute</td>
<td>60 calendar days</td>
<td>CalOptima Grievance and Appeals</td>
</tr>
<tr>
<td>Level 1 Provider Appeal Resolution Request — Zero Payment</td>
<td>60 calendar days</td>
<td>CalOptima Grievance and Appeals</td>
</tr>
<tr>
<td>Level 2 Provider Dispute Resolution Request — Zero Payment</td>
<td>60 calendar days</td>
<td>Medicare Independent Review Entity, Maximus Federal Services, Inc.</td>
</tr>
</tbody>
</table>

When the decision is not wholly in favor of the provider, Grievance and Appeals will forward the appeal case to Maximus for a Level 2 review.

If no signed waiver is submitted to Grievance and Appeals by the provider, the appeal will be dismissed.

CalOptima Policies and Procedures:
- MA.9006: Provider Complaint Process
- MA.9009: Non-Contracted Provider Payment Disputes
R6: FILING ON BEHALF OF THE MEMBER

A member’s physician or other prescriber may file a pre-service appeal on behalf of the member with member’s consent. Appeals must be requested within 60 calendar days of the date of the notice of denial for Medi-Cal, OneCare or OneCare Connect. All appeals filed by providers on a member’s behalf are processed by CalOptima’s Grievance and Appeals department through the member appeal process.

HOW TO FILE AN APPEAL ON BEHALF OF THE MEMBER

Standard pre-service appeal:

1. Notify the member that you are filing on his or her behalf.

2. Within 60 calendar days of the denial notice:
   b. Fax to 714-246-8562.
   c. Use CalOptima’s website: www.caloptima.org
   d. Mail the appeal to:
      CalOptima
      Attention: Grievance & Appeals
      505 City Parkway West
      Orange, CA 92868

Expedited pre-service appeal:

1. Within 60 calendar days, call OneCare Customer Service at 877-412-2734, OneCare Connect Customer Service at 855-705-8823 or Medi-Cal Customer Service at 888-587-8088 and request the appeal.

2. You do not need to notify the member prior to calling for an expedited appeal.

Member Complaint Form — Providers may use the Member Complaint Form to file the appeal on member’s behalf. To obtain a copy of this form, access the Providers section of the CalOptima website.

State Hearing with the California Department of Social Services (CDSS) — For Medi-Cal covered services, providers may submit a request for a state hearing on behalf of the member by contacting the CDSS within 120 calendar days of the date of the Notice of Appeal Resolution. The member must appoint the provider to be his or her authorized representative. Providers may use the Appointment of Representative Form and the Form to File a State Hearing. To obtain copies of these forms, access the Providers section of the CalOptima website.

CalOptima Policies and Procedures:
CMC.9003 & MA.9003: Standard Service Appeal
CMC.9004 & MA.9004: Expedited Service Appeal
CMC.9005 & MA.9005: Payment Appeals
GG.1510: Appeals Process for Decisions Regarding Care and Services
R7: HEARING RIGHTS

Providers who have completed the CalOptima complaint process, may request a hearing if the dispute is related to:

1. Recoupment of funds based upon audit findings of overpayment
2. Imposition of sanctions or penalties
3. Suspension or termination of the provider’s participation in CalOptima, a health network or with a third party administrator

The hearing request must be submitted to CalOptima Grievance and Appeals department in writing within 15 calendar days from the date of CalOptima’s, a health network’s or third party administrator’s complaint resolution letter. The request must specifically state the reason for the hearing request, including if the provider challenges the factual or legal basis for the decision, and or the reasonableness of the decision, sanctions or penalties imposed.

The hearing will be held within 30 calendar days of the receipt of the request. The hearing is conducted with the Provider Grievance Review Panel and is informal in nature. The provider has the opportunity to present oral testimony and written documentation. The Provider Grievance Review Panel will issue a written decision within 45 calendar days after the close of the hearing. The decision is effective the date issued by the hearing officer.

HOW TO REQUEST A HEARING

All hearing requests must be submitted in writing to:

CalOptima
Grievance and Appeals

505 City Parkway West
Orange, California 92868

Policies and Procedures:
HH.1101: CalOptima Provider Complaint
This section applies to the following CalOptima programs:

Medi-Cal

R8: LEGAL CLAIMS AND JUDICIAL REVIEW

Because CalOptima is a public agency, in addition to compliance with CalOptima’s administrative processes covered in this manual, parties must comply with the government claims requirements covered in Division 3.6 of Title I of the California Government Code, and all applicable statutes and regulations if, and as, applicable.

FOR MORE INFORMATION

Refer to CalOptima Policy AA.1217: Legal Claims and Judicial Review for guidance on filing government claims that are separate and in addition to the CalOptima administrative grievance and appeals processes.

CalOptima Policies and Procedures:

AA.1217: Legal Claims and Judicial Review
SECTION S1: INTRODUCTION- PACE

This section of the Provider Manual will help guide providers and their staff in working with the Program of All-Inclusive Care for the Elderly (PACE). The intent is to ensure that your relationship with PACE works well for you, your staff and your PACE participants.

The PACE section of the Provider Manual is to assist you with understanding the administrative processes related to providing health care services to PACE participants. PACE’s goal is to make this section of the Provider Manual as helpful as possible. This section of the Provider Manual supplements, and does not replace or supersede, the Agreement between you and PACE. Updates to this section of the Provider Manual will be made on a periodic basis in accordance with the Agreement and in response to changes in operational systems and regulatory requirements. In the event of any discrepancy between the terms of this section of the Provider Manual and the agreement, the terms of the agreement will govern.

Your satisfaction with PACE is vital to our relationship. We welcome and encourage your comments and suggestions about this section of the Provider Manual or any other aspect of your relationship with PACE. For clarification, questions or comments about your role as a Provider for PACE, please contact the CalOptima Provider Relations Department at 714-246-8600.

HISTORY AND PHILOSOPHY OF PACE

PACE is a unique program for adults over the age of 55 whose health status requires ongoing medical care and supportive services.

During the 1970s, a San Francisco-based program now known as On Lok Lifeways developed an innovative model called Program of All-Inclusive Care for the Elderly (PACE). The PACE model introduced a wide range of medical and social services designed to keep frail seniors in the community and out of institutions. Under a special waiver, Medicaid and Medicare paid On Lok Lifeways a monthly allowance for each participant, and it was On Lok Lifeway’s responsibility to arrange and provide individualized medical and social services to best serve each participant.

PACE gained public policy permanency with Medicare provider status in the late 1990s. Federal regulations delineated the requirements under Medicare and Medicaid (Medi-Cal in California) for PACE programs in November 1999. These requirements were amended in October 2002. In late 2001, the Centers for Medicare & Medicaid Services (CMS) approved the first PACE Program Agreement. By November 2003, all PACE demonstration projects had transitioned with CMS approval into permanent PACE provider status.

The CalOptima PACE program is a comprehensive health plan serving frail seniors who live in Orange County. PACE receives fixed payments (capitation) from CMS and the California Department of Health Care Services (DHCS) based on the frailty level of our population. We assume full financial risk for all the care needed by our participants.

PACE grew out of our commitment to meet the medical and social services needs of the frailest members of our community. PACE offers an important alternative when nursing home care and placement might otherwise be the only option. With PACE-provided medical, social and supportive services, frail seniors receive the assistance they need to remain within the community, enjoying the comforts of home and family for as long as possible.
PARTICIPANT ELIGIBILITY

To be eligible to participate in PACE, an adult must be:

1. 55 years of age or older
2. Live in our service area
3. Be determined eligible for nursing facility services by the State of California
4. Be able to live safely in a community setting with proper support

THE MEDICAL MANAGEMENT APPROACH AT PACE

The PACE Medical Management approach includes:

1. Integration of medical, social and supportive services
2. Care Management and delivery via an Interdisciplinary Team consisting of primary care providers, nurse practitioners, nurses, social workers, dietitians and other
3. Primary care management of specialty and institutional services
4. Continuous monitoring of medical conditions and supervision of health and safety

<table>
<thead>
<tr>
<th>PACE Program</th>
<th>Addresses</th>
<th>Phone Numbers and Website Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalOptima PACE General Information</td>
<td>13300 Garden Grove Blvd.</td>
<td>General: 714-468-1100</td>
</tr>
<tr>
<td></td>
<td>Garden Grove, CA 92843</td>
<td>Claims: 714-246-8885</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Authorizations: 714-468-1100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Website: <a href="http://www.caloptima.org">www.caloptima.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TDD Line: 714-468-1063</td>
</tr>
</tbody>
</table>

INTERDISCIPLINARY TEAM CARE PLANNING

Each PACE program has an Interdisciplinary Team (IDT) of health care professionals who are responsible for assessing and treating each participant and ensuring that their needs are met. The assessment and documentation process is referred to as the “care planning” process. The IDT must complete the participant’s care plan at enrollment, during the first quarter after enrolling, and every six months thereafter. The participants of the IDT will meet with the participant and family member(s) to assess the participant’s needs and create a care plan that works in conjunction with each of the other disciplines. This care plan is integral to the PACE model and is used as a guide for the IDT to manage the participant’s needs.

As a contracted provider for PACE, your input in the participant’s care is important and your referral notes will be documented within the participant’s medical record so that the care plan can be adjusted as necessary. Should you have questions regarding this process, please contact the PACE social worker or center manager at 714-468-1100.

<table>
<thead>
<tr>
<th>Medical Care Services</th>
<th>Long-Term Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>Transportation</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Adult Day Health Care</td>
</tr>
<tr>
<td>Medical Care Services</td>
<td>Long-Term Care Services</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>Nursing Care</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Social Work</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Physical/Occupational Therapy</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Home Care</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Audiology, Dentistry, Optometry, Podiatry, Custodial Care</td>
</tr>
</tbody>
</table>
SECTION S2: PARTICIPANT RIGHTS AND RESPONSIBILITIES

ELIGIBILITY AND VERIFICATION

1. The CalOptima PACE enrollment and intake process includes three primary stages:
   a. Initial eligibility determination
   b. Home visit
   c. PACE Interdisciplinary Team (IDT) assessment

2. As described in the Introduction, in order to be eligible to participate in CalOptima PACE, a person must:
   a. Be at least 55 years old
   b. Live in the defined CalOptima PACE service area
   c. Be determined eligible for nursing facility services by Title 22 California Code of Regulations, Sections 51334 and 51335
   d. Be able to live safely at home or in a community setting with proper support

3. Persons enrolled in PACE are referred to as participants. All PACE participants carry a unique identification card with them, which includes their assigned PACE participant number. This number is assigned upon enrollment to maintain the privacy and confidentiality of records and avoid the use of protected personal health information (PHI) as a mechanism for identification.
   a. To verify a participant’s PACE eligibility, call 714-468-1100.

4. A participant’s enrollment into CalOptima PACE is effective the first day of the calendar month following the date CalOptima PACE receives a signed signature page of the Enrollment Agreement.

PARTICIPANT BILL OF RIGHTS

CalOptima is committed to providing the highest quality of care that promotes autonomy of the individual participant and instills a level of cooperation between the participant, the family or caregiver, and the CalOptima PACE providers. In order to provide an environment that promotes privacy and dignity for each participant, as well as achieve the highest quality of care, CalOptima PACE developed a Participant Bill of Rights.

1. The staff at CalOptima PACE make participants aware of their rights in three formats:
   a. A separate document that can be used at intake and annually thereafter to remind participants of their rights
   b. Two sections of the Participant Enrollment Agreement Terms and Conditions, a document which is provided and explained at enrollment
   c. An addendum to the Enrollment Agreement

2. The Participant Bill of Rights will be displayed prominently throughout the CalOptima PACE center and be included in the Participant Enrollment Agreement Terms and Conditions.

RESPECT AND NON-DISCRIMINATION

Participants have the right to considerate and respectful care from all CalOptima PACE staff at all times and under all circumstances. They have the right not be discriminated against in the delivery of required PACE
services based on race, ethnicity, national origin, religion, sex, sexual orientation, age, mental or physical disability, or source of payment. Specifically, they have the right to be assured of the following:

1. Comprehensive health care in a safe and clean environment and in an accessible manner, and to be protected from hazardous situations

2. Dignity and respect, privacy and confidentiality, and humane care in all aspects of treatment

3. An appropriate level of care based on the participant’s individual Plan of Care

4. Reasonable access to a telephone to make and receive confidential calls or to have such calls made for them, if necessary

5. Freedom from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the participants’ medical symptoms

6. Encouragement and assistance to exercise civil and legal rights as a participant, including the Medicare and Medi-Cal appeals process, and the ability to voice grievances

7. Qualified PACE personnel who carry out the services for which they are responsible

8. Having their property treated with respect

INFORMATION DISCLOSURE

Participants have the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions. Specifically, the participant has the right to be informed by the PACE Interdisciplinary Team (IDT) verbally or in writing of:

1. Services available from PACE

2. Participant Enrollment Agreement Terms and Conditions including rights and any fees fully explained in a manner as understood by the participant

3. Rights and responsibilities of participants and of the rules and regulations governing participation in PACE, as evidenced by an acknowledgment signed by the participant

4. The participant’s health and functional status

CHOOSING A PROVIDER

Participants have the right to choose health care providers from within the PACE network, specifically in regard to the following:

1. Selecting a primary care provider (PCP) from the PACE-assigned PCPs and medical specialists from within the PACE network

2. Requesting that a qualified specialist for women’s health services furnish routine or preventive women’s health services

3. Having access to American Indian Health Services without prior authorization from the IDT
Section S2: Participant Rights and Responsibilities

4. Having access to sexually transmitted disease (STD) services and confidential HIV counseling and testing without prior authorization by the IDT

5. Being able to notify a PACE physician, PACE staff member or social worker when a second medical opinion is desired

6. Disenrolling from PACE at any time without cause

ACCESS TO EMERGENCY SERVICES
Participants have the right to access emergency health care, HIV and sensitive services when and where the need arises without prior authorization by the IDT.

PARTICIPATION IN TREATMENT DECISIONS
Participants have the right to fully participate in all decisions related to their care. If the participant lacks decision-making capacity, the family member or caregiver will be asked to designate a conservator, who will act as the substitute decision-maker. The participant has the right to:

1. Participate in the development and implementation of the Plan of Care, including knowledge of the services to be provided, frequency of services and treatment objectives.

2. Receive an explanation of treatment options in a culturally competent manner, make health care decisions, including the right to refuse treatment, and be informed of the consequences of those decisions. Assistance may be provided through an interpreter, amplification or hearing aids.

3. Request a reassessment by the IDT.

4. Receive an explanation of advance directives and establish them.

5. Receive information about their health and functional status from the IDT.

6. Receive reasonable advance notice in writing of plans for transfer to another treatment setting and the justification for the transfer.

CONFIDENTIALITY OF HEALTH INFORMATION
CalOptima PACE participants have the right to communicate with their health care providers in confidence and are entitled to have their health information safeguarded as protected health information (PHI). Other participant rights include:

1. Reviewing and copying their own medical records and requesting amendments to those records.

2. Receiving confidential treatment of all information contained in their health record

3. Obtaining their written consent for the release of information to persons not otherwise authorized under law to receive it.

4. Providing written consent that limits the degree of information and the persons to whom the information may be given.
Section S2: Participant Rights and Responsibilities

GRIEVANCE AND APPEALS

Participants have the right to a fair and efficient process for resolving differences with PACE, including a rigorous system for internal review by the organization and an independent system of external review. Participants have the right specifically to:

1. Encouragement and assistance to voice grievances to PACE staff and outside representatives of their choice free of any restraint, interference, coercion, discrimination or reprisal by the PACE staff.

2. The ability to appeal any treatment decision of PACE, its employees or contractors through a process described in the Participant Enrollment Agreement Terms and Conditions.

Refer to Section S3: Participant Grievance Process and Section S4: Participant Appeal Process of this section for more information about the participant grievance and appeals process.

PARTICIPANT RESPONSIBILITIES

At PACE, we believe that participants and their caregiver(s) play crucial roles in the maintenance of a high quality, satisfying care program. PACE participants are encouraged to establish an open line of communication with those providing care and to be accountable for the responsibilities listed below. Providers should familiarize themselves with the participant responsibilities as well.

PACE participants have the responsibility to:

1. Provide necessary and complete information for care, be involved in the development of the individualized plan of care, and pay any applicable monthly fees on time.

2. Report to the IDT if they do not clearly understand participant expectations.

3. Follow the prescribed treatment and plan of care that has been developed for them, and take prescribed medications as directed.

4. Provide accurate information to the medical and other professional staff, following instructions and cooperating with care providers.

5. Report unexpected changes in their medical condition to the responsible provider.

6. Voice any dissatisfaction with the PACE center to the PACE center director, manager, social worker or home care coordinator.

7. Show consideration of the rights of the other participants and all program personnel.

8. Attend the PACE center on the days specific to their Plan of Care, and notify the PACE Center if they are unable to come to the center on appointed days.

9. Receive all medical care from their PACE physicians or specialists, and notify PACE if they become injured.

10. Inform a PACE staff member if they are traveling so that PACE can instruct them on how to receive medical services or emergency care if they become ill while they are away.
11. Notify PACE within 48 hours or as soon as possible if the participant is away from home and an emergency arises.

**CalOptima Policies and Procedures:**

PA.2010: Enrollment and Intake
PA.5040: Participant Rights
SECTION S3: PARTICIPANT GRIEVANCE PROCESS

PACE participants have the right to a fair and efficient process for resolving differences with PACE, including a rigorous system for internal review by the organization and an independent system of external review, including the right specifically to:

1. Receive encouragement and assistance to voice grievances to PACE staff and outside representatives of participant’s choice free of any restraint, interference, coercion, discrimination or reprisal by the PACE staff

2. The ability to appeal any treatment decision of PACE, its employees or contractors through a process described in the Participant Enrollment Agreement Terms and Conditions

CalOptima PACE staff share responsibility for participants’ care and their satisfaction with the services they receive. PACE established a grievance process to address the participants’ concerns or dissatisfactions about services provided.

1. Participants receive written information of the grievance and appeals process at the time of enrollment.

2. CalOptima PACE handles all grievances in a respectful manner and maintains the confidentiality of a participant’s grievance at all times throughout and after the grievance process is completed. CalOptima PACE shall only release information pertaining to grievances to authorized individuals.

3. If the participant filing the grievance does not speak English, a bilingual PACE staff member or translation services person will be available to facilitate the process.

4. All materials describing the grievance process are available in English, Spanish, Vietnamese and other languages, as requested.

5. CalOptima PACE shall maintain a toll-free number (855-752-2584) for filing grievances and for hearing impaired participants (TDD/TTY: 714-468-1063).

6. Upon enrollment, annually and upon request, CalOptima PACE shall provide written information about the grievance process to participants and or their representatives including, but not limited to:
   a. Procedures for filing grievances
   b. Telephone numbers for the filing of grievances received in person or by telephone:
      i. PACE center manager: 714-468-1100
      ii. PACE Quality Assurance department: 714-468-1100
   iii. Locations where participants may file a written grievance:
      • CalOptima PACE center at which the participant is enrolled
      • CalOptima PACE Quality Assurance department
        13300 Garden Grove Blvd., Garden Grove, CA 92843

7. PACE staff shall not discriminate against a participant because a grievance was filed and shall continue furnishing the participant with all services at the frequency provided in the current plan of care during
the grievance process.

8. CalOptima PACE expects providers to be familiar with the grievance procedures as established by CalOptima PACE.

9. Any method of transmission of the participant’s grievance information from one staff member to another is in the strictest confidence, in adherence with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

HOW PARTICIPANTS MAY FILE GRIEVANCES

1. Participants and or their representative may voice a grievance to a PACE staff member in person, by telephone or in writing to a PACE location.

2. A grievance form will be available from the PACE Quality Assurance department, which may be provided to a participant and or his or her representative with the report form, if requested. In order to access the grievance form, contact the PACE center at 714-468-1100, or refer to the PACE section of the CalOptima website at www.caloptima.org/.

3. Any CalOptima staff person can assist a participant and or his or her representative with filing a grievance in the event that assistance is required.

DOCUMENTATION OF GRIEVANCES

1. A CalOptima staff person will make sure the participant has written information regarding the grievance process and document the grievance on the grievance report form on the day of receipt of the grievance or as soon as possible after occurrence of the events.

2. The CalOptima PACE Quality Assurance department shall ensure documentation of complete details of the grievance so that the grievance may be resolved within 30 days. The participant may take further action if they are unsatisfied with the resolution.

3. In the event that a resolution is not reached within 30 calendar days, the participant and or his or her representative shall receive written notice of the status and estimated completion date of the grievance resolution.

4. The PACE Quality Assurance department shall acknowledge the participant’s grievance within five calendar days of receipt of the grievance and shall be responsible for coordinating the investigation, designating the appropriate PACE staff participants to take corrective action(s), and reporting the grievance to the interdisciplinary team (IDT).

5. If the participant feels their grievance involves an imminent and serious threat to their health including, but not limited to, potential loss of life, limb or major bodily function, severe pain, or violation of their participant rights, the PACE Quality Assurance department shall expedite the review process to a decision within 72 hours.

6. Upon PACE’s completion of the investigation and reaching a final resolution of the grievance, the participant will receive written notification with a report describing the reason for the grievance, a summary of actions taken to resolve the grievance and options to pursue if the participant is not satisfied with the resolution of the grievance.
GRIEVANCE REVIEW OPTIONS

After the participant completes the grievance process, or participates in the process for at least 30 calendar days, and the participant is dissatisfied with the resolution of the grievance, the participant may pursue other options as described below. If the situation represents a serious health threat, the participant and or his or her representative need not complete the entire grievance process, nor wait 30 calendar days to pursue the options listed below.

1. If the participant is eligible for Medi-Cal only, or Medi-Cal and Medicare, he or she is entitled to pursue the grievance with the California Department of Health Care Services (DHCS) by contacting or writing:

   Ombudsman Unit
   Medi-Cal Managed Care Division
   Department of Health Care Services
   P.O. Box 997413
   Mail Station 4412
   Sacramento, CA 95899-7413
   Telephone: 888-458-8609
   TTY: 800-735-2922

2. At any time during the grievance process, whether the grievance is resolved or unresolved, the participant and or his or her representative may request a state hearing from the California Department of Social Services by contacting or writing:

   California Department of Social Services
   State Hearings Division
   P.O. Box 944243, Mail Station 19-17-37
   Sacramento, CA 94244-2430
   Telephone: 800-952-5253
   Facsimile: 916-651-5210 or 916-651-2789
   TDD: 800-952-8349

3. Participants must request a state hearing within 90 days from the date of receiving the letter for the resolved grievance. The participant and or his or her representative must speak at the state hearing or have someone else speak on their behalf, such as a relative, friend or attorney.

4. CalOptima PACE assures that every grievance is handled in a consistent manner and that there is communication among the different individuals who are responsible for reviewing or resolving grievances. In order to ensure all participant concerns are addressed and resolved, PACE will also maintain appropriate documentation, so the information can be utilized in PACE’s Quality Assurance program.

HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT GRIEVANCE PROCESS

CalOptima PACE grievance procedures enable participants and their families to express any concerns, grievances or dissatisfactions they may have so that CalOptima PACE may resolve them in a prompt and respectful manner. When appropriate, the provider may assist the participant in filing a grievance.

As a provider for PACE, the provider may become aware of a participant with a problem or complaint about PACE, its policies or providers.
As a provider, you should have the participant or his or her representative call the CalOptima PACE Quality Assurance department at **714-468-1100**, or provide information on participant grievance procedure and a grievance form. The grievance form is in the PACE section of the CalOptima website at [www.caloptima.org/](http://www.caloptima.org/).

**PARTICIPANT COMPLAINTS ABOUT PROVIDERS**

- A provider may be notified of a complaint filed against them by a participant or his or her representative.
- If a grievance related to services provided by a CalOptima PACE contracted provider arises, the PACE Quality Assurance department shall notify the contracted provider’s quality assurance staff.

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<th>CalOptima Policies and Procedures:</th>
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<td>PA.7001: Grievance Process</td>
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SECTION S4: PARTICIPANT APPEAL PROCESS

All CalOptima PACE staff share responsibility for the care and satisfaction that participants receive. The appeals process enables the participant and or their representative the opportunity to respond to a decision made by the interdisciplinary team (IDT) regarding a request for a service or payment of a service.

1. At any time the participant wishes to file an appeal, PACE staff is available to assist the participant. If the participant does not speak English, a bilingual staff member or translation services will be available to him or her.

2. Participants will not be discriminated against because they filed an appeal. PACE will continue to provide the participant’s plan of care during the appeals process.

3. Confidentiality of the appeal will be maintained at all times throughout and after the appeals process including, but not limited to, transmission of appeal information from one CalOptima PACE staff member to another in adherence to Health Insurance Portability and Accountability Act (HIPAA) regulations; information pertaining to the appeal will only be released to authorized individuals.

4. Participants will receive written information on the appeals process at the time of enrollment, annually thereafter, and whenever the IDT denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:
   a. Procedures for filing an appeal, including participant’s external appeal rights under Medi-Cal and Medicare
   b. Telephone number for the filing of an appeal received in person or by telephone:
      PACE center manager: 714-468-1100
      PACE Quality Assurance department: 714-468-1100

5. A participant and or his or her representative may file a written appeal at either of the following locations:
   a. CalOptima PACE center at which the member is enrolled
   b. 13300 Garden Grove Blvd., Garden Grove, CA 92843

6. Contracted providers are accountable for all appeal procedures established by CalOptima PACE and will be monitored by CalOptima PACE for compliance with this requirement on an annual or as-needed basis.

7. All written materials describing the appeal process are available in English, Spanish, Vietnamese and other languages, as requested.

8. CalOptima PACE shall maintain a toll-free number (855-785-2584) for the filing of an appeal and for hearing impaired participants (TDD/TTY: 714-468-1063).

FILING AN APPEAL

1. The appeal process is available to any participant, his or her representative, or treating provider, who disputes denial of payment, or the denial, deferral, or modification of a service by the primary care provider (PCP), or any member of the IDT who is qualified to make referrals.
2. A participant may file any appeal for denial, deferral, or modification of a service or payment for a service verbally or in writing.

STANDARD AND EXPEDITED APPEALS

1. A participant may file an appeal as standard or expedited, depending on the urgency of the case.

2. A participant may file a standard appeal verbally or in writing with any PACE staff member within 180 calendar days of a denial of service or payment. CalOptima PACE may extend the 180-day limit for good cause by CalOptima PACE.

3. A participant may file an expedited appeal verbally or in writing to CalOptima PACE if the participant or provider believes that the participant’s life, health or ability to regain maximum function would be seriously jeopardized without provision of the service in dispute.

4. For participants enrolled in Medi-Cal, CalOptima PACE shall continue to furnish the disputed service if both of the following conditions are met:
   a. CalOptima PACE is proposing to reduce or terminate services currently being furnished to the participant
   b. The participant requests continuation of the service with the understanding that he or she may be liable for the cost of the contested service if the determination is not made in his or her favor.

5. Under the circumstances listed above, CalOptima PACE shall not discontinue the disputed service for which an appeal was filed until the appeal process concludes.

6. The PACE Quality Assurance department shall acknowledge a standard appeal in writing within five business days of the initial receipt of appeal by CalOptima PACE.

7. For an expedited appeal, the PACE Quality Assurance department shall inform the participant or representative within one business day by telephone or in person that the request for an expedited appeal was received and explain his or her additional appeal rights, as applicable.

8. CalOptima PACE shall document in an appeal log all appeals expressed, either verbally or in writing, on the day that the appeal is received or as soon as possible after the event or events that precipitated the appeal.

9. Appeals are documented on the appeals form by the participant, his or her representative, or by a treating provider on behalf of the participant. Complete information is required so the appeal can be resolved in a timely manner. For access to the appeals form, please contact the PACE center at 714-468-1100, or refer to the PACE section of the CalOptima website at www.caloptima.org/.

10. In the event of insufficient information, the PACE Quality Assurance department shall take all reasonable steps to contact the participant, and or his or her representative, or other appropriate parties to the appeal, to obtain missing information in order to resolve the appeal within the designated time frames for an expedited or standard appeal.

11. All individuals involved with the appeal, including the participant or representatives, shall be given written notice of the appeals process and reasonable opportunity to present evidence or submit relevant facts for review to CalOptima PACE, either verbally or in writing.
12. For a standard appeal, the PACE Quality Assurance department shall inform the participant in writing of the decision to reserve or uphold the decision within 30 calendar days of receipt of an appeal, or more quickly if the participant’s health condition requires.

13. For an expedited appeal, CalOptima PACE shall make a decision regarding the appeal as promptly as the participant’s health condition requires, but no later than 72 hours after receipt of the request for appeal.
   a. The PACE Quality Assurance department shall provide the participant and or his or her representative and the Department of Health Care Services (DHCS) with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of appeal.
   b. In the event that the 72-hour time frame needs to be extended, the PACE program director shall provide justification to DHCS regarding the need for extension. The participant shall be notified, both verbally and in writing, by the PACE Quality Assurance department of the pending status and the reason for the delay with the appeal. CalOptima PACE shall notify the participant of the anticipated date by which the appeal decision shall be determined.

THE DECISION ON THE APPEAL

1. When the decision of an appeal is in favor of a participant, that is, the decision to deny, defer or modify a service or payment of a service is reversed, the following shall apply:
   a. The PACE Quality Assurance department shall provide a written response to the participant or representative within 30 calendar days of receiving a standard appeal, or sooner if the participant’s health condition requires.
   b. For an expedited appeal, CalOptima PACE shall provide the participant permission to obtain the disputed service or provide the service as quickly as the participant’s health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.

EXTERNAL REVIEW OPTIONS FOR APPEAL — MEDI-CAL

The Medi-Cal external appeal process option is available to participants enrolled in either Medi-Cal only, or Medicare and Medi-Cal.

If the participant and or representative chooses to appeal using the Medi-Cal external process, the PACE Quality Assurance department shall assist the participant and forward the appeal to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: 1-800-952-8349

1. CalOptima PACE shall not discontinue services for which an external appeal is filed until the external appeal process concludes.

2. If the participant and or his or her representative decides to pursue a state hearing, he or she must request the state hearing within 90 days from the day of the Notice of Action (NOA), in which the participant receives notification of the denial, deferral, or modification of service, or denial of payment for a service.
EXTERNAL REVIEW OPTIONS FOR APPEAL — MEDICARE

The Medicare external appeals process option is available to participants enrolled in either Medicare only, or Medicare and Medi-Cal.

1. A Medicare enrollee may choose to appeal CalOptima PACE’s decision using Medicare’s external appeals process.

2. Standard appeals are resolved within 30 calendar days after the filing of the appeal; expedited appeals are resolved within 72 hours, with a possible 14-day extension.

3. The Medicare appeals entity will notify CalOptima PACE with the results of the review.

4. If the decision is not in the participant’s favor, there are further levels of appeal; upon request the PACE Quality Assurance department will assist a participant in further pursuing the appeal.

HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT APPEALS PROCESS

The provider may assist the participant in requesting an expedited appeal if the provider or participant believes that the participant’s life, health or ability to get well is in danger without the service they want. In order to view the Appeal for Reconsideration of Denial form, providers may refer to the PACE section of the CalOptima website at [www.caloptima.org](http://www.caloptima.org).

CalOptima Policies and Procedures:
PA.7002: Appeal Process
SECTION S5: PROVIDER RIGHTS AND RESPONSIBILITIES

PROVIDER REGISTRATION

CalOptima PACE requires providers and practitioners furnishing services to CalOptima PACE participants to register with CalOptima PACE. CalOptima PACE uses the provider registration process to support accurate and timely adjudication of claims. New providers and practitioners can register for the first time with CalOptima PACE through the Providers section of the CalOptima website at www.caloptima.org, while existing providers can make changes to their registration information online, by phone or fax.

How to Complete the Initial Registration with CalOptima PACE

New providers and practitioners can register online through the Providers section of CalOptima’s website. Providers registering online must meet identified conditions or provide the following information:

1. Active status with Department of Health Care Services (DHCS)
2. National Provider Identifier (NPI)
3. Tax Identification Number (TIN)
4. State medical license
5. Malpractice/liability insurance information (carrier and aggregate amounts)
6. DHCS certification license (if applicable)
7. Service address and phone number
8. Supervising physician name and license number (if applicable for non-physician medical practitioner)

How to Change an Existing Provider’s Registration Information

1. Existing providers may change their registration information by:
   a. Emailing Provider Data Management Services at provideronline@caloptima.org
   b. Faxing the provider’s new information to 714-954-2330

2. The types of changes that the provider or practitioner may make to his or her registration information include:
   a. Terminations
   b. Additional addresses
   c. Phone/fax/email updates
   d. Tax Identification Number (TIN) changes (requires submission of a new W-9)

PROVIDER RESPONSIBILITIES

Participants choose their own primary care provider (PCP) from among the PACE contracted primary care physicians. The PCP acts as the primary care manager to all assigned participants and is part of the interdisciplinary team. The PCP is responsible for conducting a physical during the intake process. The results of this physical, along with the documentation from the rest of the IDT, will determine whether the participant may enroll in PACE and will assist with the development of the plan of care. Most PCPs for participants are retained on staff by CalOptima PACE, although some PCPs may be contracted providers. The vast majority of PACE contracted providers are medical specialists.
The PCP should:

1. See each assigned participant at least every three months.
2. Attend a weekly IDT meeting to discuss the health status of their participants.
3. Coordinate and direct appropriate care for participants by means of initial diagnosis and treatment, obtaining second opinions, as necessary, and consulting with the contracting specialists.
4. Follow up on referrals made to the specialists to assess the result of the care, medication regimen and special treatment to ensure continuous care.
5. Be available to provide health care services 24 hours a day, 7 days a week.

PACE will assist the PCP as follows:

1. Coordinate the necessary specialist visits, make appointments with the specialist and transport the participant to the appointment.
2. Discourage inappropriate use of medications through utilization review and the input of our pharmacy consultant.
3. Help educate the participant on disease prevention practices and early diagnostic services.
4. Assist in the transfer of the participant to another PCP, if necessary, or as requested.

**CONTRACTED PROVIDER RESPONSIBILITY FOR CONTINUITY OF CARE**

In the event of a contract termination, the provider shall acknowledge responsibility for the continuity of care for PACE participants receiving a course of treatment under the provider’s care for an acute condition or serious chronic condition at the time of contract termination. Eligible participants have the right to request that the terminated provider continue to provide, and be compensated for, those services that are covered by PACE.

**Eligibility for Continuity of Care**

A PACE participant is eligible for continuation of care if they experience an acute condition or serious chronic condition. An acute condition is defined as a medical problem that involves a sudden onset of symptoms due to disease, illness or other medical problem that requires prompt medical attention and that has a limited duration.

A serious chronic condition means a medical condition due to disease, illness or other medical problem or medical disorder that is serious in nature and results in either of the following:

1. Persists without full care or worsens over an extended period of time
2. Requires ongoing treatment to maintain remission or prevent deterioration

**Contracted Provider Responsibility**

Contracted providers will be responsible for providing continuing care under the following conditions:

1. Contracted provider’s termination or non-renewal was voluntary.
2. Contracted provider agrees in writing to be subject to the same contractual terms and conditions of his or her agreement including, but not limited to, credentialing, hospital privileges, utilization review, peer review and quality assurance requirements.
3. Contracted provider agrees in his or her contract to accept the payment rates and payment methodologies outlined in the agreement.
4. The extent and duration of the continuation of covered services will be as follows:
   a. If the requesting participant is undergoing a course of treatment from the provider for an acute condition or serious chronic condition, the provider will furnish services on a timely and appropriate basis for up to 90 days, or a longer period, if necessary, for the transfer to another
provider, as determined by PACE and in consultation with the terminated provider, consistent with good professional practices.

b. This continuity of care will not require PACE to cover services or provide benefits that are not otherwise covered under the terms and conditions of PACE.

**Process to Request Continuity of Care**

When a provider terminates, PACE sends a letter to participants currently under the care of that provider, giving them the provider’s termination date and advises that their care will be transferred to another provider. PACE informs the participant by letter that they may request to continue to see the terminated provider based on continuity of care eligibility criteria and sends a form to the participant to complete. If requested by the participant, PACE will arrange for care to continue under existing conditions until course of treatment is over or until a suitable transfer can be made.

**PROVIDER RIGHTS AND DISPUTE PROCESS**

PACE will make every effort to assist a provider in the resolution of complaints or problems encountered while providing health care to PACE participants. For utilization management and prior authorization issues, please see Section S8: Utilization Management and Authorization for Services or contact the PACE center at 714-468-1100. For billing and payment issues, please see Section S7: Claims Submission and Process or contact the Claims department at 714-246-8885.

Providers can also contact the PACE director or the Quality Assurance manager at 714-468-1100 who will work with other CalOptima departments, as necessary, to respond to the provider’s specific issue and come to a resolution.

**Summary of the Dispute Process**

If not resolved after attempting to go through the department and staff identified above, providers can report any administrative, operational, contractual or claims or payment concerns, issues or disputes to CalOptima’s Grievance and Appeals (GARS) department in writing. Disputes must be filed within 365 calendar days of PACE action, or in the case of inaction, within 365 calendar days after the time for contesting or denying claims that expired. Please submit the provider dispute in writing to the Grievance and Appeals department at the following address:

CalOptima
GARS
505 City Parkway West
Orange, CA 92868
714-246-8554

1. GARS will acknowledge receipt of the dispute either within 15 business days or within two business days if the dispute is sent electronically.
2. If the information provided in the written dispute is not adequate, Grievance and Appeals will request missing or additional information in writing.
3. The returned complaint shall clearly identify, in writing, the missing reasonably relevant information or information necessary to determine payer liability.
4. The provider may submit an amended dispute within 30 working days of the request for additional information.
5. Depending on the issue, the Grievance and Appeals department will contact the appropriate PACE or CalOptima department to facilitate a resolution.
6. All provider disputes will be resolved within 45 working days from the date of receipt. Details of the resolution or corrective action plan, including the date implemented, are communicated to the provider in writing.

Implementation of the resolution will adhere to the following time frames:

- Immediately upon decision, whenever possible
- For issues of payment, if the resolution involves additional payment to the provider, the payment will be made no later than 5 working days from the date of resolution
- For all non-payment-related issues, no later than 30 calendar days from the date of determination, except in extenuating circumstances

When making a complaint, provider should make sure to include the following:

1. Provider’s name and identification number (i.e., NPI)
2. Provider’s contact information including address, telephone number and fax number of the provider’s contact person
3. An explanation of the dispute or issue, including any relevant attachments, documentation and supplemental information
4. If the dispute involves a service provided to a PACE participant, include the participant’s name, participant’s identification number and date of service.

CalOptima Policies and Procedures:
MA.9006: Provider Complaint Process
SECTION S6: QUALITY MANAGEMENT AND CREDENTIALING

QUALITY MANAGEMENT OVERVIEW
CalOptima PACE has a Quality Assurance and Performance Improvement (QAPI) program. The QAPI program enables PACE to measure, assess and improve important aspects of health care delivery and the health care outcomes of our participants.

QUALITY PROGRAM GOALS
The QAPI program at PACE adheres to the principles of the National Committee on Quality Assurance (NCQA). QAPI objectively and systematically monitors and evaluates the quality and appropriateness of participant care quarterly and ad hoc across the entire continuum of care delivered by CalOptima PACE, and reports results to the Medical Advisory Committee and the CalOptima Board of Directors. The goals of the review process are to assure high-level quality care and to identify, assess and reduce problems affecting care to an acceptable level.

The QAPI program is reviewed and revised annually. The CalOptima Board of Directors annually reviews results and approves the QAPI program.

QUALITY MANAGEMENT
As part of the QAPI, providers are monitored for:

1. Participant access to care and availability of care and services
2. Compliance with PACE policies and procedures
3. Participant satisfaction with care provided
4. Coordination of care by the primary care provider (PCP), medical specialists, mental health providers and community facilities caring for the participant
5. Cultural and linguistically appropriateness of care, including availability of bilingual staff and telephonic language assistance services
6. Program performance and resource utilization management

By monitoring services and addressing problems as they arise, PACE is able to keep its mission and vision of providing quality, affordable care services for the well-being of the frail elderly and to continually lead the movement to improve care for the elderly.

QUALITY EXPECTATIONS FOR MEDICAL SPECIALISTS
Upon receiving authorization from PACE, the medical specialist will:

1. Set specialty appointment within 14 days of the request.
2. Communicate findings of the visit to the PCP, including recommendations for further diagnostic procedures or therapy.

3. Coordinate lab and X-ray request(s) with the PACE center.

4. Maintain medical records consistent with state and federal regulations.

5. Comply with PACE QAPI policies and procedures.

6. Contact PACE to refer to another medical specialist who is out of the PACE panel of providers.

7. Provide continuity of care services to PACE participants upon termination of a provider’s contract.

QUALITY ASSURANCE PROVISIONS FOR PROVIDERS

In addition to complying with the PACE credentialing requirements detailed in this section, the provider is to cooperate and comply with quality assurance provisions including coordination of care, accessibility standards, office waiting time, participant satisfaction surveys, grievance and appeal activities, and communication regarding unusual incidents.

Upon request, the provider may receive a copy of the PACE QAPI manual. In order to access the QAPI manual, contact the quality assurance coordinator at 714-468-1100, or refer to the PACE section of the CalOptima website at www.caloptima.org/.

CREDENTIALING OVERVIEW

The purpose of the CalOptima credentialing process is to verify that participating physicians and other professionals have the necessary and appropriate credentials to provide their services to participants. Providers who are interested in contracting with PACE may initiate the credentialing process by contacting CalOptima’s Provider Relations department at 714-246-8600. The information listed below informs the provider of the credentialing process.

In conducting the credentialing and recredentialing processes for PACE, CalOptima verifies specific information, including:

1. California licensure
2. Current professional liability insurance or self-insurance
3. The provider’s primary admitting facility
4. Exclusions, suspensions or ineligibility to participate in any state or federal health care program
5. Active Medi-Cal/ Medicare provider identification number
6. Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate
7. Education and training, including board certification (if the provider states on the application that he or she is board certified)
8. Work history
9. Status of clinical privileges
10. History of professional liability claims
11. Licenses of any mid-level providers employed under the provider, as well as verification of liability insurance coverage for the mid-level providers

**HOW TO COMPLETE THE INITIAL CREDENTIALING PROCESS**

Providers interested in contracting with CalOptima PACE must be credentialed. AppCentral is CalOptima’s online system to process credentialing applications electronically. To begin the credentialing application process, please follow the steps below:

1. Call CalOptima’s Provider Resource Line at **714-246-8600**, and CalOptima staff will complete an Initial Credentialing Application Information form and submit the completed form to CalOptima’s Credentialing department.

2. CalOptima’s Credentialing department will send the provider an emailed invitation to participate in the AppCentral credentialing application process.

3. CalOptima will render a decision within 180 calendar days from the date of signature attestation.

4. If a provider is not able to use AppCentral, CalOptima will send a credentialing application by email or fax. Provider can return the completed application and required documents by fax to **714-481-6474**, or by email to **HNpractitioner@caloptima.org**.

**HOW TO COMPLETE THE REcredentialing PROCESS**

1. At the time of recredentialing (every three years after initial approved credentialing date), the provider will receive a recredentialing package from CalOptima. The provider will receive an email from AppCentral with a pre-populated application. The provider will be required to complete identified areas of the application and verify information provided on the application is current. The provider will be instructed to forward the completed application and required documents to an identified CalOptima credentialing coordinator.

2. If a provider is unable to forward the application via email, the completed application and required documents can be faxed to **714-481-6474**.

3. CalOptima will render a decision within 180 calendar days from the date of signature attestation.

For questions regarding the credentialing or recredentialing process, please contact CalOptima’s Provider Resource Line at **714-246-8600**.

**FACILITY SITE REVIEW, MEDICAL RECORDS REVIEW**

CalOptima conducts a full-scope facility site review of the CalOptima PACE center as part of its credentialing and recredentialing process. This includes a facility site review (FSR), medical records review (MRR) and physical accessibility review survey (PARS). The purpose of the FSR, MRR and PARS is to ensure that the CalOptima PACE center meets certain minimum state-required standards for their office sites for maintenance of patient medical records and to ensure physical accessibility for participants with disabilities.
CalOptima conducts a full-scope facility site review during the initial credentialing process and every three years thereafter.

**KEY POINTS REGARDING THE FSR, MRR AND PARS**

1. The FSR includes an on-site inspection and interviews with office personnel.

2. The MRR uses a survey of 10 randomly selected medical records. The MRR review includes, but is not limited to, a review of format, legal documentation practices, and documentary evidence of the provision of preventive care and coordination of primary care services.

3. The PARS surveys the facility site access for participants with disabilities to parking, the building, elevators, doctor’s office, exam rooms and restrooms. The survey will also identify if an exam room has a height-adjustable exam table and accessible weight scale for those with disabilities.

4. CalOptima has minimum standards for maintaining member medical records. The following are some of the required elements for maintaining member medical records. For more information on maintaining member medical records, please refer to CalOptima Policy GG.1603 Medical Records Maintenance.
   a. Designate an individual responsible for the medical records system.
   b. Label and file all active records in the system to facilitate retrieval on demand.
   c. Store active records in a secure area.
   d. Retain inactive records for five years.
   e. File in the medical record within 48 hours of receipt: lab, X-ray, EEG, EKG, consultation reports, hospital and ED reports.
   f. Date and sign medical records after each encounter.
   g. Have a system in place to identify, monitor and follow up on participants who do not keep appointments (no shows).
   h. Maintain confidentiality of medical records.

5. If CalOptima identifies deficiencies during the full-scope facility site review, CalOptima will give the PACE center a Corrective Action Plan, which includes specific time frames for addressing identified deficiencies. CalOptima will not allow the PACE center with major uncorrected deficiencies to provide care to its participants until the identified deficiencies have been corrected.

For more information about the full-scope facility site review process, please call CalOptima’s Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

**CalOptima Policies and Procedures:**
- GG.1603: Medical Records Maintenance
- GG.1604: Confidentiality of Credentialing Files
- GG.1608: Full Scope Site Reviews
- GG.1608a: Facility Site Review Process
- GG.1608b: Medical Records Review Process
- GG.1609: Credentialing and Recredentialing
- MA.7011b: Medical Records Review Process
SECTION S7: CLAIMS SUBMISSION AND PROCESS

CalOptima providers rendering services to PACE participants must submit claims using the current version of the CMS 1500 claim form for professional services or a UB 04 form for facility services. When submitting the claim, please be sure to include all required data elements in order to ensure timely payment. Providers must follow all Medi-Cal and or Medicare rules and regulations for billing.

FORMS

Contracted Fee-For-Service (FFS) providers rendering services to PACE participants must submit claims using a CMS 1500 claim form (outpatient visit). Facilities must use a UB 04 form (both inpatient and outpatient visits) to submit claims.

Providers can download copies of both the CMS 1500 and UB 04 forms from the CMS website at CMS Forms List.

CLAIMS PROCESSING OVERVIEW

CalOptima recognizes that a key component of quality health care is timely and efficient medical claims processing. CalOptima processes medical claims primarily per Medi-Cal and Medicare guidelines, and utilizes key industry standard codes and guidelines to promote timely and efficient processing of paper and electronic claims. Below is a summary description of CalOptima’s claims processing steps.

Claims Filing Time Frames

PACE follows the Centers for Medicare and Medicaid Services (CMS) and Medi-Cal guidelines for timely filing of claims. Providers should file claims within the applicable time frames.

- Providers have one year from the date of service to submit a claim for covered services.
- The CalOptima Claims department will deny claims not submitted within the appropriate time frame.

Edits/Audits

- CalOptima processes all claims on a first-in, first-out basis.
- All claims are subject to a comprehensive series of checks called “edits” and “audits.” The checks validate all data information to determine if the claim should be paid, contested or denied. Edit/audit checks review:
  a. Data validity
  b. Prior authorization requirements
  c. Recipient eligibility on date of service
  d. Provider eligibility on date of service
  e. Procedure/diagnosis, and procedure/modifier compatibility
  f. Other insurance coverage
  g. Potential for claim duplication
- CalOptima will provide a clear and accurate explanation of the specific reasons for adjusted, denied or contested claims.
Section S7: Claims Submission and Process

**ELECTRONIC CLAIMS SUBMISSION**

CalOptima accepts claims in both electronic and hard copy formats. This section provides information about electronic claims submission, including Electronic Data Interchange (EDI) claims, and Long-Term Care (25-1) electronic billing.

CalOptima strongly encourages electronic claims submission. What are the benefits of submitting claims electronically to CalOptima?

- Electronic claims submission is cost-effective.
- Providers receive an electronic confirmation of claim submission (from the clearinghouse).
- Electronic submission promotes effective utilization of staff resources.

**HOW TO SUBMIT ELECTRONIC CLAIMS TO CALOPTIMA**

**EDI Claims**

CalOptima has contracts with data clearinghouses to receive EDI claims. There is no cost to the provider for the services provided by these two clearinghouses.

To register and submit electronically, contact one of the vendors listed below:

**Emdeon**
877-271-0054
[www.emdeon.com/](http://www.emdeon.com/)

**Office Ally**
866-575-4120
[www.officeally.com/](http://www.officeally.com/)

**CalOptima Payer Identification Numbers**

Provider should use the following CalOptima payer identification (ID) numbers when sending claims electronically to CalOptima. (Note that Emdeon and Office Ally have their own payer identification number and each vendor processes different types of claims):

- **Emdeon: Payer ID “99250”** — For submission of Long-Term Care claims and Facility claims (UB)
- **Office Ally: Payer ID “CALOP”** — For submission of Professional (CMS 1500) and Facility (UB) claims
- **Long-Term Care Services — (25-1 Form Electronic Billing)** — CalOptima contracts with Emdeon to provide electronic billing for Long-Term Care claims in accordance with the billing requirements and fields on the 25-1 Form. To register for Long-Term Care (25-1 Form) electronic billing, please contact Emdeon at the phone number referenced above.

**GUIDELINES FOR HARD COPY CLAIMS SUBMISSION TO CALOPTIMA**

CalOptima accepts claims in both electronic and hard copy formats. This section provides information about hard copy claims submission, including guidelines for how to complete the claim form, important tips and relevant billing addresses.

This section explains the basic billing guidelines required for CalOptima processing of hard copy medical CMS 1500 and UB 04 claim forms. Copies of both the CMS 1500 and UB 04 forms may be downloaded from the CMS website at: [CMS Forms List](http://www.cms.gov)
Following these guidelines helps ensure that CalOptima can pay a provider’s hard copy claim quickly and accurately:

1. **Type in Designated Area Only**
   All claims are scanned, so it is important that providers input data on the claim form only in the designated fields. Be sure the data falls completely within the text space and is properly aligned. This will ensure that claims are scanned accurately and avoid rejections or payment delays.

2. **Use Alpha or Numeric Characters Only**
   Use only alphabetical letters or numbers in data entry fields as appropriate. Only use symbols such as “$, #, cc, gm” or positive (+) and negative (–) signs when entering information in the Specific Details/Explanation/Remarks or the Reserved for Local Use fields of the claim form.

3. **Do Not Use Highlighting Pens**
   Please do not highlight information. When the form and attachments are scanned on arrival at CalOptima, the highlighted area will show up as a black mark, covering the information highlighted.

4. **Follow the Date Format**
   Enter dates in the six-digit format (MMDDYY) without slashes. Refer to the sections of this guide covering claims form completion for appropriate billing form instructions and for additional date format information.

5. **Cover Corrections**
   Do not strike over errors. Do not use correction fluid. Do not use correction tape.

6. **Be Sure to Reference Claim Fields or Procedures on Attachments**
   Attached documents for medical claim forms and Provider Dispute Resolution forms should clearly reference the claim field number or procedure that requires additional documentation.
   
   a. The claim field number on the attachment should be legible, underlined or circled in black ballpoint pen. Allow adequate line space between each claim field number description.
   
   b. Attach undersized documentation to an 8 1/2 x 11-inch sheet of 20 lb. white bond paper with non-glare tape. Cut oversized attachments in half (e.g., Explanation of Medicare Benefits, Medicare Remittance Notice, Remittance Advice), and tape each half to a separate 8 1/2 x 11-inch white sheet of paper; staple attachments in the top right corner of the form.

   **Note:** Do not highlight or use tape to fasten attachments to the claim form. Do not use original claims as attachments since they may not be interpreted as original claims. Carbon copies of documentation are not acceptable.

**OTHER IMPORTANT TIPS WHEN SUBMITTING BILLS TO CALOPTIMA**

1. **Timely Filing**
   CalOptima has timely filing guidelines that allow the provider one year from the date of service to submit a claim. CalOptima will deny claims not submitted within the appropriate time frame. The claim may be submitted for reconsideration with documentation showing that the claim was submitted timely (e.g., retro eligibility issue).

2. **Paper Claims and Submission**
   When submitting paper claims to CalOptima, providers should send the original claim form and retain a copy for their records.
3. **Submission Standards**
   Providers should not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.

4. **Unacceptable Forms**
   Carbon copies, photocopies, facsimiles or forms created on laser printers are not acceptable for claims submission and processing.

5. **Point of Service (POS) Printouts**
   Point of Service (POS) printouts, with Eligibility Verification Confirmation (EVC) numbers, are not required attachments unless the claim is over one year old.

**HARD COPY CLAIMS SUBMISSION TO CALOPTIMA**

To submit a claim in hard copy format to CalOptima, please mail to:

Original Claims  
CalOptima Claims Department  
P.O. Box 11037  
Orange, CA 92856

**CO-PAYMENTS**

There are no co-payments or deductibles for PACE participants.

**ADJUSTED, DENIED OR CONTESTED CLAIMS**

CalOptima will provide a written clear and accurate explanation of the specific reasons for such action for adjusted, denied or contested claims.

**POTENTIAL BILLING DISCREPANCIES**

Should billing discrepancies occur, CalOptima will try to resolve the discrepancy. We may request a copy of the medical record or supplemental information. We will supply a written clear and accurate explanation detailing the necessity for the request.

**INCOMPLETE OR PENDING CLAIMS**

Claims that fail an edit or audit check will “pend” for review by a claims examiner who will identify the reason for the pended status and examine the scanned image of the claim and attachments (if hard copy received). If the examiner detects input errors, the examiner will correct the error and the claim will continue processing. A physician or other qualified medical professional will review claims requiring medical judgment in accordance with the provisions of the Centers for Medicare & Medicaid Services (CMS), California Code of Regulations (CCR), Title 22 and policies established by the Department of Health Care Services (DHCS).

**SERVICES PROVIDED WITHOUT PRIOR AUTHORIZATION**

In cases where participants pay out of pocket for non-emergency services without prior authorization, CalOptima will pay such claims at the discretion of the interdisciplinary team (IDT) and or the medical director. If the services are deemed not medically necessary or an alternate in-network provider was available, the social worker will discuss payment responsibility with the participant.
CHECKING THE STATUS OF A CLAIM ONLINE

Providers can view claims or check status on CalOptima Link located on CalOptima’s website at www.caloptima.org. New users will need to register with CalOptima Link. Follow the instructions for checking the status of a claim or a check.

For more information regarding CalOptima Link, see Section E1: Verifying Member Eligibility.

PROBLEMATIC CLAIMS

Claims for which CalOptima establishes reasonable grounds for suspicion of possible fraud, misrepresentation or unfair billing practices will be forwarded to the PACE medical director and or other outside agencies for review.

CLAIMS PAYMENTS

CalOptima will pay claims to providers within 45 working days from receipt by CalOptima’s Claims department. Claims that successfully pass the processing cycle will be adjudicated per regulatory guidelines and or the specific contracted rate. Providers shall not seek additional payments from Medi-Cal and Medicare, other insurance companies or PACE participants. For payment of non-authorized services in which the participant is deemed responsible, as determined by PACE policies and procedures, PACE staff will speak to the participant and or family regarding payment.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at 714-246-8885, Monday through Friday, from 8 a.m. to noon and 12:30 to 4 p.m.

For questions regarding the submission of claims, contact CalOptima’s Claims department at 714-246-8885.
This section applies to the following CalOptima programs:

PACE

SECTION S8: UTILIZATION MANAGEMENT AND AUTHORIZATION FOR SERVICES

CalOptima PACE assures quality of care by establishing overall organizational controls including a process for utilization management and review. The utilization management program at PACE is separate from CalOptima’s Utilization Management department because PACE relies on the professional judgment of its staff and primary care providers (PCPs) to make medical care decisions. The interdisciplinary team (IDT) also makes decisions in their respective disciplines. The only exceptions are in instances of out-of-network services or a standing referral to a psychiatrist or psychologist that exceeds six months in duration. Both must be approved by the PACE medical director.

PACE provides comprehensive medical and long-term care services to keep participants safe in the community. PACE participants receive care with few prior authorization requirements. The following procedures must be followed for all routine services provided to CalOptima PACE participants:

1. All non-emergency services must be authorized by CalOptima PACE prior to services being rendered.

2. Providers who render emergency services must notify CalOptima PACE within 24 hours or on the next business day after that service has been rendered.

3. CalOptima PACE will contact the provider by telephone requesting the specific service. A Contract Provider Referral form will be completed at that time and forwarded to the provider.

4. The provider will receive a provider referral form at the time of the participant visit.

In order to access the Contract Provider Referral form, call the PACE center at 714-468-1100, or refer to the PACE section of the CalOptima website at www.caloptima.org/.

There are three general areas where authorization may be required for some services:

1. Referral to a specialist or diagnostic center

2. Services recommended by a specialist or another physician not in concurrence with the participant’s PCP

3. Services which must be approved by the interdisciplinary team (IDT)

Emergency services, preventive services, sensitive services and confidential services do not require prior authorization by PACE.

The Request for Service Consultation form states the reason for referral and the scope of the requested service and will include a numeric authorization number. A provider is to respond to the referring PACE PCP in writing regarding the professional opinion, recommended treatment plan and anticipated follow-up care. All additional services recommended by a provider, including referrals to other providers, diagnostic tests and treatments must be explicitly authorized by PACE.
INTERDISCIPLINARY TEAM APPROVAL REQUIREMENTS

The interdisciplinary team will consider the services listed below for approval based on the PACE authorization criteria, medical necessity, and or ability for the service to improve the participant’s quality of life significantly:

- Home care service
- PACE center attendance
- Rehabilitation services
- Nursing home placement
- Durable medical equipment (DME) and other supplies
- Glasses, hearing aids and dentures
- Nutritional supplements
- Portable meals

SERVICES NOT IN CONCURRENCE WITH PACE PCP

As described above, all additional services recommended by a provider, including referrals to other providers, diagnostic tests and treatments, must be specifically authorized by PACE. In most cases, the PCP will authorize the additional service, test or treatment, with the exception of the services listed below, which will be considered by the PACE medical director for approval based on authorization criteria, medical necessity and or ability for the service to improve the participant’s quality of life significantly:

- Referral to an out-of-network provider
- Standing referral to a psychiatrist or psychologist that exceeds six months in duration

DOCUMENTING A SERVICE REQUEST

Once the PCP has made the decision to refer a participant to an off-site provider, the PCP or designee will generate a Request for Service Consultation form and a PACE staff person will call the provider’s office to arrange the appointment.

The Request for Service Consultation form includes the following:

- PACE address, telephone number and an authorization number (providers rendering services to PACE participants should place the authorization number on a CMS 1500 claim form for professional services)
- Participant’s full name, date of birth and participant number
- Appointment time and date
- Who authorized the referral, date of authorization and reason for consultation
- A section for a referral provider’s report

The participant or representative will bring the Request for Service Consultation form to the scheduled appointment or fax the form in advance to 714-468-1071. When services are rendered, the provider will complete the “Referral Provider’s Report” section of the Request for Service Consultation form including a professional opinion, recommended treatment plan, anticipated follow-up care, and signing and dating the form. All additional services recommended by the provider must be explicitly authorized by PACE.

The provider’s office staff will make a copy of the completed Request for Service Consultation form for the participant’s medical record and fax the form to 714-468-1071.

In order to access the Request for Service Consultation form, call the PACE center at 714-468-1100, or refer to the PACE section of the CalOptima website at www.caloptima.org/.
EXCEPTIONS TO AUTHORIZATION REQUIREMENTS

There are specific categories of care for which no authorization is required. PACE covers both emergency services and urgently needed care when a participant is temporarily out of the approved service area but still in the United States, Canada, and Mexico.

Emergency Services include inpatient or outpatient services furnished immediately in or outside the service area because of an emergency medical condition. An emergency medical condition is a medical condition that is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of a participant in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgently Needed Services are covered services necessary to prevent serious deterioration of the health of a participant, resulting from unforeseen illness, injury, prolonged pain, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the participant returns to the PACE service area.

Sensitive Services are covered services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

DENIAL, DEFERRAL OR MODIFICATION OF A SERVICE REQUEST

PACE shall issue a Notice of Action for Service or Payment Request, also referred to as a denial letter, for any authorization situation that results in a decision to deny, defer or modify a service request. The form will provide the reason for denial, deferral or modification and then instruct the participant or the participant’s representative to file an appeal if they do not agree with the action. Information regarding the appeals process should accompany the Notice of Action for Service or Payment Request form, refer to the PACE section of the CalOptima website at www.caloptima.org. For questions regarding authorizations, call the PACE Center at 714-468-1100.

PRESCRIPTION DRUG BENEFITS

Each participant enrolled in CalOptima PACE is entitled to Medicare and Medi-Cal covered services, including prescription drugs. The participant’s PCP is responsible for managing the care of the participant, including prescription drugs; the PCP may also review recommendations for drug therapy. PACE will not assume financial responsibility for unauthorized drugs or medications dispensed by another pharmacy except in the case of an emergency. PACE participants do not pay any co-payments or deductibles for covered services, including prescription drug coverage benefits.

DISCHARGE PLANNING

Upon discharge from an inpatient hospital, the PACE PCP or designee coordinates discharge planning with the hospital.

TRANSPORTATION SERVICES

PACE provides or otherwise arranges for transportation to and from the provider’s service location. PACE may also provide an escort for the participant.
TRANSLATION SERVICES

As detailed in the Cultural and Linguistic program requirement description in Section S10: Additional Resources and Information, PACE shall arrange for translation services when appropriate.

CalOptima Policies and Procedures:
AA.1000: Glossary of Terms
MA.1001: Glossary of Terms
SECTION S9: SENSITIVE AND CONFIDENTIAL SERVICES

TESTING

All providers must obtain written consent for confidential human immunodeficiency virus (HIV) testing, except when a treating physician or surgeon recommends the test or it is provided at an alternative test site. Under these circumstances, a physician or surgeon may obtain verbal informed consent from the participant.

Disclosure of Test Results

Provider must obtain consent for disclosure of a participant’s HIV test results (California Health and Safety Code, Section 120980). Provider must obtain written authorization from a participant prior to each separate disclosure of an HIV test result. Under the law, a physician or surgeon may disclose a participant’s test result to a person reasonably believed to be the spouse, sexual partner or person with whom the participant has shared hypodermic needles, but only if the physician or surgeon provided education and counseling to the participant and attempted to obtain the participant’s voluntary consent to notify his or her contacts. The physician or surgeon is prohibited from disclosing any identifying information about the participant during the notification (California Health and Safety Code, Section 121015).

DISCLOSURE OF BILLING INFORMATION

When a participant is tested by someone other than the primary care provider (PCP), the participant may elect to:

- Sign a release of confidential information to send medical records and the bill to PACE.
- Allow billing information to be sent to PACE, but refuse to release medical records.
- Choose complete anonymity and refuse to release any information.

NOTE: A claim submitted without a name to determine eligibility for services will not be paid by PACE.

In accordance with state and federal regulations, PACE participants have open access to sexually transmitted diseases (STD) services and acquired immune deficiency syndrome (AIDS) services. Therefore, PACE participants may receive such services from their PACE PCP, a non-assigned PCP, a contracted medical specialist or an out-of-network provider, including family planning clinics, community clinics or health department clinics and programs.

SEXUALLY TRANSMITTED DISEASES (STD)

Providers are responsible for filing all required reports on STD diagnosis and treatment as required by law. Such reporting should be documented in the participant’s medical record. Providers are responsible for informing the participant of this reporting activity.

Providers are encouraged to ask the participant to authorize the release of diagnosis and treatment information to the participant’s PCP in order to ensure continuity of care. Provider must inform participants of their right to refuse or agree to disclose such information. Medical records must be in accordance with state law and professional practice standards on confidentiality.
HIV/AIDS TESTING

PACE policy is to ensure that participants receive information regarding access to confidential HIV counseling and testing.

Providers should advise any participant who chooses to go to an out-of-network confidential test site to sign a release of information form to allow submission of his or her name on the claim. PACE will not reimburse the provider for a claim submitted without the name to determine eligibility for services.

According to California law, providers must report AIDS cases to the County Public Health Department, Division of Communicable Disease Control and Prevention. AIDS is a reportable condition and does not require consent from the participant. Providers are required to report the names of individuals diagnosed with AIDS.

Providers should be aware of the following laws regarding confidentiality and consent for HIV services:

ACCESS FOR THE DISABLED

All PACE provider facilities should be accessible and useable by individuals with disabilities in accordance with the Americans with Disabilities Act of 1990. Access includes physical, alternative and communication accommodations.

Physical Accommodations

Physical accommodations should include:

- Wheelchair access, ramp
- Water availability/water fountain at wheelchair level
- Elevators with floor selection within reach
- Designated parking spaces
- Accessible bathroom or alternative access to bathroom in the building
- Handrails in the bathrooms
- Hallways and exits must not be locked to impair wheelchair access

CalOptima will evaluate the PACE center for access to the disabled during the facility site reviews.

Alternative Accommodations

Providers in older facilities that are inaccessible should make alternative arrangements for treating disabled participants. If it is not possible to find an alternative, a provider should refer the participant to a provider who can meet the participant’s needs.

Communication Accommodations

In addition, providers should make appropriate language and communication accommodations, such as provision of sign language interpretation, telecommunications devices for the deaf (TDD/TTY) and or interpreters.

Detailed Infection Control Standards

PACE providers are to maintain and follow infection control policy and procedures. Providers are responsible for training all staff in universal precautions and hand washing, the use and maintenance of the autoclave, cleanup of blood spills, isolation procedures and disposal of biohazardous waste.
INFECTION DISEASE REPORTING

Each provider office must have an established procedure to meet regulations for reporting of infectious diseases to the local health authority (California Administrative Code, Title 17). Providers may request recommendations on treatment procedures from the local public health department. Using a current version of reportable diseases, providers must perform necessary and required epidemiological follow up and institute preventive measures per the local public health department’s instructions.

**Reporting Form for Participants**

Providers must complete the Confidential Morbidity Report (available from the local public health department) and send it to the local authorities. The date the report was sent should be documented in the participant’s medical record.

**Confidentiality**

Information about participants with reportable infectious diseases will be kept confidential and protected from unauthorized disclosure as required by California law.

**Reportable Diseases/Additional Reporting Requirements**

When reporting certain infectious diseases, providers must also provide additional specific information regarding hepatitis and STDs:

**Hepatitis Report**

- Type
- Type-specific laboratory findings
- Source of exposure

**Sexually Transmitted Infections Report**

- Information as to causative agent
- Syphilis-specific laboratory findings
- Complications of gonorrhea or chlamydia infections

**DETAILED MEDICAL RECORDS STANDARDS**

All PACE providers are required to have a medical record for each participant and to maintain procedures for storage, filing, retrieval, protection of confidentiality and release of information.

**Maintenance**

Providers must specify a staff member to maintain medical records in order to assure records are:

- Secured from unauthorized use
- Stored in one central medical records area
- Kept current and accessible for care
- Organized in sections
- Securely fastened
- Filed in a manner that assures the ability to retrieve them, either alphabetically by last name, first, middle, or numerically using a terminal digit, serial or uniquely assigned numbering system
Confidentiality

- While the physical medical record belongs to the provider, the information in the record belongs to the participant and must be protected from unauthorized disclosure.
- The medical records department manager or office manager shall be responsible for maintaining, monitoring and enforcing staff compliance in keeping member information confidential, and in the release of member information when requested by the member, or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, and CalOptima Health Insurance Portability and Accountability Act (HIPAA) privacy policies.
- Federal HIPAA privacy regulations require that participants complete the Authorization for Use or Disclosure of Protected Health Information (PHI) form to authorize CalOptima to use or disclose participants’ PHI to another person or organization. In order to view the Authorization for Use or Disclosure of Protected Health Information (PHI) form, visit the PACE section of the CalOptima website at www.caloptima.org/.
- Federal HIPAA privacy regulations allow participants the right of access to inspect and obtain a copy of their health information contained in a Designated Record Set by completing the Individual Request for Access to Protected Health Information (PHI) form. However, this right does not apply to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. In order to view the Individual Request for Access to Protected Health Information (PHI) form, visit the PACE section of the CalOptima website at www.caloptima.org/.

MEDICAL RECORD CONTENT

Providers must meet the standards for medical record documentation in accordance with the National Committee on Quality Assurance (NCQA) and by the state Medi-Cal Program Regulations (Title 22 of the California Code of Regulations). Each medical record must comply with the standards summarized below.

Patient Identification

- Each page in the record contains the participant’s name or ID number.

Personal Biographical Information

- Personal biographical data includes, but is not limited to: name and address, age and birth date, sex, telephone number, emergency contact person and nearest relative (phone numbers for each), plan identification, Medi-Cal number, preferred language, and the request or refusal of language assistance services.

Entries

- All entries in the medical record contain author identification and are made in accordance with acceptable legal or documentation standards.
- The record shall reflect the findings of each visit or encounter including, but not limited to, recording the date of service, chief complaints, follow up from previous visits, tests or therapies ordered, treatment plan and diagnosis or medical impression, any physical, psychosocial, or educational needs identified during the encounter, and abnormal results.

Legibility

- The record shall be in a legible handwritten or a printed format.
Specific Conditions

- There is a distinct and separate problem list that includes all significant illnesses and medical conditions including allergies and adverse reactions. If the participant has no known history of adverse reactions, this is appropriately noted on the problem list.
- A separate medication list is maintained for all current medication. The list includes medication name, strength, dosage, frequency, route, and start or stop dates. Also note discontinued medications on the medication list.
- Documentation of appropriately obtained informed consent form is maintained.

Medical History

- Past medical history is easily identified and includes serious accidents, operations, significant health problems, reactions to drugs, and personal habits such as alcohol, drugs, smoking, sexual activity and diet.
- History and physical records contain appropriate subjective and objective information pertinent to the participant’s presenting complaints.
- Appropriate history of immunization records is maintained.

Preventive Health Services

- Documentation of all clinical preventive services is included in the participant’s medical record.

Diagnoses, Treatment and Follow Up

- Laboratory studies and other studies as ordered appropriate
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- Encounter forms or notes have notation when indicated regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous visits are addressed in subsequent visits.

CalOptima Policies and Procedures:
GG.1603: Medical Records Maintenance
SECTION S10: ADDITIONAL RESOURCES AND INFORMATION

CULTURAL AND LINGUISTICS PROGRAM

Cultural and linguistic competence among health care providers is essential to the care and satisfaction of recipients of health care services. The Cultural and Linguistics (C&L) program is designed to ensure that participants, both with and without English proficiency, have access to quality health care and services that are culturally and linguistically appropriate. Specifically, CalOptima’s C&L program will focus on three main areas: participants, staffing and providers, and competency.

Participants

- All PACE participants have the right to interpreter services provided by PACE.
- PACE provides written materials for participants in English, Spanish, Vietnamese and other languages, as requested.

Staffing and Providers

- CalOptima PACE attempts to recruit culturally and linguistically appropriate staff to better serve its diverse participant population. When a certain linguistic capacity is needed, but not available among the CalOptima PACE staff, PACE staff may access translation services.
- CalOptima PACE offers participants access to providers who are culturally and linguistically similar to the diverse population that PACE serves.

Competency

- CalOptima PACE offers current staff and providers the opportunity to self-report their C&L competence when they are hired or contracted.
- PACE will provide translation services if a certain linguistic capability is unavailable and needed.
- PACE contracts with professional translators to translate written materials into the preferred and or primary languages of the participants.
- PACE has competent staff proofread translated written materials to ensure accuracy, clarity and reading ease.

HEALTH EDUCATION PROGRAM

- Whenever possible, CalOptima PACE provides appropriate quality health care information and education to its participants in an easily accessible manner, based on individual needs.
- Based on the assessment by the IDT, and upon request from the participant, PACE provides education by:
  a. Distributing to all participants at enrollment general health education materials focused on topics of interest to a frail, elderly population, such as osteoporosis, arthritis and blood pressure
  b. Distributing discipline-specific clinical materials, determined by each clinical discipline, as part of the participant’s plan of care
  c. Offering direct evaluation through one-on-one counseling with a participant and or family member or caregiver and presenting general group education sessions
If a provider has a participant who identifies an area where health education would be important, the provider should notify a PACE IDT member. CalOptima PACE is committed to meeting the individual needs of their participants.

TRANSPORTATION SERVICES

- All PACE participants have access to medical transportation which includes the following:
  a. Transportation provided by PACE or a contracted outside service
  b. Basic life support (BLS) provided by emergency medical technicians for non-emergency transportation of stable patients
  c. Advanced life support (ALS) provided for use in response to “9-1-1” requests. Ambulance paramedics provide care.
  d. Non-ambulatory transportation for participants requiring wheelchair or other assisted transport to medical appointments or other covered services
  e. Critical care transportation for participants requiring a higher level of care for services not routinely available at the facility to which they were initially admitted

ADVANCE HEALTH CARE DIRECTIVES

- Upon enrollment in CalOptima PACE, the primary care provider (PCP) or social worker verifies whether a participant has signed an advance directive. If the participant does not have an advance health care directive and wishes to complete one, the social worker provides assistance, as needed. The advance directive will become part of the participant’s medical record.

EXPERIMENTAL AND INVESTIGATIONAL THERAPIES

- PACE usually does not cover experimental and investigational procedures and therapies. Participants may be considered on a case-by-case basis for such therapies.
- PACE should contact the participant’s PACE PCP for further information regarding PACE coverage for a proposed experimental and or investigational therapy.