CalOptima Health

Provider Manual

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

For access to CalOptima Health's policies and procedures and common forms, please visit the Provider section of CalOptima Health's website.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare, PACE

A1: WELCOME TO CALOPTIMA HEALTH!

Thank you for your interest and participation in CalOptima Health. We are a county organized health system (COHS) that administers health insurance programs for Orange County children, low-income families, seniors and people with disabilities. Through the collaboration of physicians, care managers and other health care providers, CalOptima Health's health insurance programs are built on a foundation of comprehensive and coordinated patient-centered care.

We recognize that the strength of our programs depends upon strong collaboration and communication with our provider partners and their staff. Our mission is to serve member health with excellence and dignity, respecting the value and needs of each person and we look forward to working together in service to our members. high-quality, cost-effective care.

INTENT OF THIS MANUAL

This provider manual is a communication tool and a reference guide for CalOptima Health's providers and their office staff. It contains basic information about how to work with CalOptima Health. 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 Health-related transaction
- How to get more information

NOTICE: CalOptima Health 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. Reviews by the Quality Improvement Committee (QIC) and Member Advisory Committee (MAC) are conducted on an annual and as-needed basis. In the event of a conflict or inconsistency between this manual and other documents or laws, the following apply in the order of descending precedence: federal and state statutes, regulations and regulatory guidance, the provider contract with CalOptima Health, CalOptima Health policies and procedures, and, finally, this manual.

HOW TO USE THE MANUAL

We drafted the manual so that it is easy to search and access through CalOptima Health's website. Providers can simply search for 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 Health
- Services Covered by Other Agencies
- Eligibility Verification and Enrollment
- Authorization and Referral Guidelines
- Claims and Billing Guidelines
- Pharmacy and Prescriber Information
- Basic Population Health Management

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 at **714-246-8600** or providerservicesinbox@caloptima.org with any suggestions for additions or improvements to this manual.

BACKGROUND ON CALOPTIMA HEALTH

CalOptima Health is a COHS that manages programs funded by the state and federal governments but 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 Health was created by the 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 more than 1,200 primary care providers, 9,100 specialists, 550 pharmacies and a majority of hospitals and long-term care facilities in Orange County.

We currently provide health coverage through three major programs:

- **Medi-Cal**
- **OneCare (HMO D-SNP) a Medicare Medi-Cal Plan**
- **PACE (Program of All-Inclusive Care for the Elderly)**

Our mission is simple:

To serve member health with excellence and dignity, respecting the value and needs of each person.

CALOPTIMA HEALTH'S PROGRAMS

Medi-Cal

Medi-Cal is California's Medicaid program for low-income families, children, seniors and people 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 in Orange County through the County of Orange Social Services Agency (SSA) 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 recertify 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 cases, 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 a CalOptima Health identification card alone is not a guarantee of eligibility.

Not all Medi-Cal beneficiaries are CalOptima Health members. Those who are not members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries bill and are 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 Health should be submitted to the Medi-Cal field office, not to CalOptima Health.

Newly eligible Medi-Cal beneficiaries are covered through FFS Medi-Cal for their initial month of eligibility. New members will then be assigned to CalOptima Health 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 Health will be responsible for any covered services if the member is enrolled with CalOptima Health, 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 Health. 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 Health for the entire process. CalOptima Health will be responsible for services provided to a CalOptima Health 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 Health.

OneCare

OneCare is CalOptima Health's Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Patients who are dually eligible for Medicare (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 (QMB) program or the Specified Low-Income Medicare Beneficiaries (SLMB) program.

OneCare offers 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.

PACE

PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to vulnerable seniors 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 Health'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 Health PACE providers and will be personally responsible for any unauthorized or out-of-network services.*

CALOPTIMA HEALTH'S DELIVERY SYSTEM

Providers have several options for participating in CalOptima Health's programs. Providers can contract with a CalOptima Health health network or participate through CalOptima Health Direct (COD) or the CalOptima Health Community Network (CCN).

CalOptima Health 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 Health 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.

Health Network*	CalOptima Health Program	Delegated Responsibilities
AltaMed Health Services	Medi-Cal, OneCare	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 Health.
AMVI Care Health Network	Medi-Cal	Professional, facility and ancillary services
AMVI/Prospect Medical Group	OneCare	Professional services and most ancillary services are the responsibility of the Shared-

Health Network*	CalOptima Health Program	Delegated Responsibilities
		Risk Group. Facility services and some ancillary services are the responsibility of CalOptima Health.
CCN	Medi-Cal, OneCare, CalOptima Health Direct	Professional, facility and ancillary services
CHOC Health Alliance	Medi-Cal	Professional, facility and ancillary services
Family Choice Health Network	Medi-Cal, OneCare	Professional, facility and ancillary services
HPN-Regal Medical Group	Medi-Cal	Professional, facility and ancillary services
Noble Mid-Orange County	Medi-Cal, OneCare	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 Health.
Optum	Medi-Cal, OneCare	Professional, facility and ancillary services
Prospect Medical Group	Medi-Cal	Professional, facility and ancillary services
United Care Medical Group	Medi-Cal, OneCare	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 Health.

**Note: Pharmacy services are not delegated to the health networks.*

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

CalOptima Health Direct	CalOptima Health Program	Membership Criteria
CalOptima Health Direct Administrative	Medi-Cal	Transitional members waiting to be assigned to a delegated health network Medi-Cal/Medicare Members (Medi-Medi)

CalOptima Health Direct	CalOptima Health Program	Membership Criteria
		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 Health's programs, providers can call CalOptima Health's Provider Resource Line at **714-246-8600**.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare, PACE

B1: CALOPTIMA HEALTH DEPARTMENT AND PROGRAM CONTACT INFORMATION

CALOPTIMA HEALTH CONTACT INFORMATION

Contact Information	Phone Numbers and Website Addresses
CalOptima Health general information	505 City Parkway West Orange, CA 92868 General: **714-246-8500** Claims: **714-246-8600** Authorizations: **714-246-8686** Website: www.caloptima.org TTY Line: **711**
CalOptima Health PACE	13300 Garden Grove Blvd. Garden Grove, CA 92843 **714-468-1100** **855-785-2584** (toll free)
CalOptima Health website	www.caloptima.org
Provider Resource Line	**714-246-8600**
Case Management department	**714-246-8686**
Claims: CalOptima Health Direct claims Dual Eligible Claims (Crossover claims) Provider Dispute Resolution Claims	P.O. Box 11037 Orange, CA 92856 **714-246-8600** P.O. Box 11070 Orange, CA 92856 **714-246-8600** P.O. Box 57015 Irvine, CA 92619

Contact Information	Phone Numbers and Website Addresses
	714-246-8600
Customer Service	**714-246-8500** or **888-587-8088** (toll free)
Eligibility Verification	https://www.caloptima.org/en/ForProviders/ProviderPortal.aspx
Compliance and Ethics Hotline	**877-837-4417**
Grievance and Appeals (complaints)	505 City Parkway West Orange, CA 92868 **714-246-8600**
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 **714-246-8600**
Multipurpose Senior Services Program (MSSP)	**714-246-8500** or **888-587-8088** (toll free)
Perinatal Support Services	**714-246-8686**
Prior Authorization/CalOptima Health Direct	**714-246-8686** or **888-587-7277** (toll free)
Provider Data Management Services (PDMS)	P.O. Box 11033 Orange, CA 92856 **714-246-8468**
CalOptima Health Provider Portal	https://www.caloptima.org/en/ForProviders/ProviderPortal.aspx
MedImpact Healthcare Systems Inc. (Pharmacy Benefit Manager)	Medi-Cal: 888-807-5705 (toll free) OneCare: 800-819-5480 (toll free)
MedImpact Healthcare Systems Inc. (Prior Authorizations)	Phone: 888-807-5705 (toll free) Fax: 858-357-2557 (toll free)

Contact Information	Phone Numbers and Website Addresses
California Children's Services (CCS)	714-347-0300
Medi-Cal Dental Program	800-322-6384 (toll free) TTY: 800-735-2922 (toll free)
Medi-Cal Benefits/Department of Health Care Services (DHCS)	916-552-9797
Member Eligibility Verification (AEVS) — DHCS	800-456-2387 (toll free)
CalOptima Health Behavioral Health	**855-877-3885** (toll free)
Regional Center of Orange County (RCOC) Referrals	714-796-5354
Vaccines for Children (VFC)	877-243-8832
Vision Service Plan (VSP)	Providers: 800-615-1883 (toll free) Members: 800-852-7600 (toll free)

HEALTH NETWORK CONTACT INFORMATION

Health Networks	Addresses	Phone Numbers and Website Addresses
CalOptima Health Community Network	505 City Parkway West Orange, CA 92868	General: **714-246-8500** Claims: **714-246-8600** Authorizations: **714-246-8686** Website: www.caloptima.org TTY Line: **711**
AltaMed Medical Group (SRG) Medi-Cal, OneCare	2040 Camfield Avenue Los Angeles, CA 90040	General: 866-880-7805 Claims: 855-848-5252 Authorizations: 855-848-5252 Website: www.altamed.org TTY Line: 714-246-8523

Health Networks	Addresses	Phone Numbers and Website Addresses
AMVI Care Health Network (PHC) Medi-Cal, OneCare	600 City Parkway West Suite 1000 Orange, CA 92868	General: 866-796-4245 24-Hour: 888-747-2684 (toll-free) Website: http://www.prospectmedical.com
CHOC Health Alliance (PHC) Medi-Cal	1120 W. La Veta Ave. Suite 450 Orange, CA 92868	General: 800-387-1103 (toll-free) 24-Hour: 800-387-1103 (toll free) Website: www.chochealthalliance.com
Family Choice Health Services (HMO) Family Choice Health Network (SRG) Medi-Cal, OneCare	7631 Wyoming Street, Suite 202 Westminster, CA 92863	General: 800-611-0111 (toll free) 24-Hour: 800-611-0111 (toll free) Website: www.familychoice.com
HPN-Regal Medical Group (HMO) Medi-Cal, OneCare	8510 Balboa Blvd. Suite 285 Northridge, CA 91325	General: 800-292-5173 24-Hour: 800-292-5173 (toll-free) Website: www.heritageprovidernetwork.com
Noble Mid-Orange County (SRG) Medi-Cal, OneCare	5785 Corporate Avenue Cypress, CA 90630	General: 888-880-8811 (toll free) 24-Hour: 888-880-8811 (toll free) Website: www.noblemidoc.com
Optum Medi-Cal, OneCare	11 Technology Drive Irvine, CA 92618	General: 888-656-7523 (toll free) Claims: 888-767-2222 24-Hour: 888-656-7523 (toll free) Website: www.monarchhealthcare.com
Prospect Medical Group (HMO) Medi-Cal, OneCare	600 City Parkway West Suite1000 Orange, CA 92868	General: 800-708-3230 (toll free) 24-Hour: 800-708-3230 (toll free) Website: www.prospectmedical.com
United Care Medical Group (SRG) Medi-Cal, OneCare	600 City Parkway West Suite 1000 Orange, CA 92868	General: 877-225-6784 (toll-free) 24-Hour: 877-225-6784 (toll free) Website: www.prospectmedical.com

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): An SRG is a physician group partner that accepts delegated clinical and financial responsibility for professional services for assigned members and enters into a risk-sharing agreement with CalOptima Health 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 Health to provide covered services to their assigned members. Please contact the member's assigned HMO for additional information regarding covered services.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

B2: PROVIDER RESOURCES ON CALOPTIMA HEALTH'S WEBSITE

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

- **Provider Portal** — Contracted providers can use the CalOptima Health Provider Portal to verify eligibility, check the status of a CalOptima Health claim and submit referrals for CalOptima Health Direct or CalOptima Health Community Network members. Learn how to register for and utilize the Provider Portal using the following link: https://www.caloptima.org/en/ForProviders/ProviderPortal.aspx.

- **Provider Manual** — General information about the provision of health care goods and services for CalOptima Health members.

- **Provider Directory** — Search by CalOptima Health program, health network, name, specialty or location.

- **Pharmacy Resources** — Obtain CalOptima Health's Approved Drug List and locate CalOptima Health contracted pharmacies.

- **Common Forms** — Find forms for everything from Wheelchair Repair Authorization Referrals to appeals and grievances.

- **Health and Wellness Library** — Materials are available in PDF format to download in all of CalOptima Health's threshold languages.

- **Provider Communications** — Monthly provider newsletter, Provider Update, based on recent Operating Instruction Letters received by the Department of Health Care Services.

- **CalOptima Health Policies and Procedures via Compliance 360** — A complete library of CalOptima Health policies by program.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

C1: COVERED SERVICES OVERVIEW

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

MEDI-CAL-COVERED SERVICES ADMINISTERED BY CALOPTIMA HEALTH

Medi-Cal-covered services administered by CalOptima Health 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 (DME)
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CalOptima Health's Child Health and Disability Prevention [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
- Mental health and substance use disorder services

MEDI-CAL-COVERED SERVICES NOT ADMINISTERED BY CALOPTIMA HEALTH

CalOptima Health 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**)
- 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's covered benefits include services that are covered under Medicare but also 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 services
- Skilled nursing facility
- Home health care
- Hospice
- Chiropractic services
- Podiatry services
- Outpatient mental health services
- Outpatient substance abuse services
- Medically necessary ambulance services
- Non-emergency medical transportation
- Emergency services
- Urgent care
- Outpatient rehabilitation services
- DME
- 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 section of CalOptima Health's website.

This section applies to the following CalOptima Health 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.

EPSDT services include medically necessary behavioral health treatment (BHT) for Medi-Cal eligible individuals less than 21 years of age. BHT includes, but is not limited to, applied behavior analysis (ABA).

SERVICES PROVIDED UNDER EPSDT

EPSDT supplemental services include, but are not limited to:

- Acupuncture
- Audiology
- Behavioral Health Treatment (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 provider has a member who requires EPSDT services, with the exception of BHT, the provider should complete an Authorization Request and submit it to either CalOptima Health (if the member is in CalOptima Health Direct) or to the member's health network prior authorization department.
2. Providers must accompany authorization requests with medical documentation sufficient to support the medical necessity of the services. Required documentation must include **all** of the following:

   a. Completed prior authorization request form
   b. Current nursing plan of treatment, signed by a physician
   c. Assessment of nursing notes

3. On review of the materials and request, medical necessity criteria as detailed above will be applied.
4. If you have questions regarding EPSDT, call CalOptima Health or the health network's prior authorization department.
5. If a provider has a member who requires BHT, the provider should refer the member to call CalOptima Health Behavioral Health at **855-877-3885.** This line is available 24 hours a day, seven days a week. TTY users can call **800-735-2929**.

CalOptima Health Policies and Procedures:

GG.1121: EPSDT Supplemental Services

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

C3: HOSPICE SERVICE REFERRALS

Hospice services are a covered benefit for CalOptima Health Medi-Cal and OneCare members. CalOptima Health 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 (SNF), 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 Health.

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 the 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 Health and its health networks, including 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 the 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 Health member is enrolled with a health network (including CCN) or in COD, 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 Health Direct Medi-Cal Only Members, including CCN** — If a member is in COD or CCN, CalOptima Health is responsible for ensuring services are provided and paid for under Medi-Cal hospice services and hospice room and board per Medi-Cal guidelines (see DOFR). CalOptima Health members who require hospice respite care, continuous care and routine home care, provided in a long-term care (LTC) nursing facility, do not require prior authorization. General inpatient care does require prior authorization. For CalOptima Health members in an LTC nursing facility only, fax the Authorization Request Form for General Inpatient Hospice Care to CalOptima Health's Long-Term Support Services (LTSS) at **714-246-8843**.

- **CalOptima Health Direct Medicare/Medi-Cal Members** — For COD Medicare-Medi-Cal members, Medicare covers hospice services, while COD 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 (PCP) 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 COD, and they are in an LTC nursing facility, the hospice agency will submit a Notification/Validation form to CalOptima Health's LTSS at **714-246-8843**. The Notification/Validation of Hospice services will be confirmed for hospice room and board.

3. CalOptima Health will not require hospice providers to submit authorization requests for hospice routine care, hospice continuous care or respite care. Nor will the health plan issue approval or acknowledgment letters for hospice routine care, hospice continuous care or respite care, including hospice room and Board requests.

4. For more information, please contact CalOptima Health's LTSS department at **714-246-8600**.

5. If the member is dually eligible for Medicare and Medi-Cal, the hospice provider will work with Medicare for the Medicare services.

CalOptima Health Policies and Procedures:

GG.1503: CalOptima Health Hospice Coverage Notification and Validation Requirements

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

C4: LONG-TERM CARE SERVICE REFERRALS

CalOptima Health is responsible for Medi-Cal-covered long-term care services. CalOptima Health 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 that CalOptima Health Long-Term Support Services (LTSS) authorizes only for room and board:

- Nursing Facility Level A (NF-A) and Level B (NF-B)
- Subacute Care Facilities — both adult and pediatric facilities

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.

- Skilled Nursing Facilities (SNF) for Medicare Part A Nursing Services are reviewed and approved by Utilization Management.
- 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 are reviewed and approved by the Regional Center of Orange County (RCOC)

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 Health 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.

TIPS FOR REFERRING A MEMBER TO A NURSING FACILITY

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

1. To refer a member to a nursing home, the physician must order the admission and provide 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 Health's website, which contains the list of CalOptima Health's contracted facilities: www.caloptima.org.

3. The admitting facility is responsible for obtaining authorization from CalOptima Health. 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 the 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 Health's Grievance and Appeals 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 Grievance and Appeals if presented within 365 days of the original decision.
   c. For more information on how to file an appeal, please see **Section R1: Provider Complaint Process.**

PLAN OF CARE FOR ONECARE MEMBERS

1. OneCare 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 (as per the state and federal guidelines for a long-term care nursing facility).

2. A nursing facility may modify its care or discharge a OneCare member if the nursing facility determines that the following specified circumstances are present, and a 30-day notice has been given to the member by the nursing facility (unless waived by the member and/or responsible party):
   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 Health 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 Health or its health networks shall arrange, coordinate and collaborate with the nursing facility to discharge a OneCare 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 Health LTSS staff shall review the plan of care when completing the initial authorization and during a reauthorization of services, 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
   c. Has a sudden increase in polypharmacy
   d. Has an initial and annual health risk assessment

For questions about the Medi-Cal long-term care benefit or about referrals to long-term care facilities, please call CalOptima Health Long-Term Care at **714-246-8600**.

CalOptima Health Policies and Procedures:

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

GG.1808: Plan of Care, Long-Term Care

This section applies to the following CalOptima Health programs:

Medi-Cal

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, transportation, home-delivered meals, social services and other services. MSSP is a statewide program funded by the California Department of Aging (CDA) that CalOptima Health administers as a 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 would otherwise be in a nursing facility)
- Be age 65 or older
- Receive Medi-Cal under an appropriate aid code (1E, 2E, 6E, 1X, 1Y, 10, 14, 16, 17, 1H, 20, 24, 26, 27, 60, 64, 66, 67 and 6H)
- 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, or managing serious health conditions.
- "Ability/willingness to participate" means that the member is likely to cooperate in formulating and then carrying out the care plan.

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

CASE MANAGEMENT AND COORDINATION OF CARE

- CalOptima Health and its affiliated health networks will work with the CalOptima Health MSSP provider to provide case management and coordination of care for CalOptima Health members.
- CalOptima Health's MSSP provider will participate in the care management team that includes an Interdisciplinary Care Team (ICT) of health professionals.
- CalOptima Health informs its members about CalOptima Health MSSP 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 to the MSSP provider for eligibility determination.
- CalOptima Health and the CalOptima Health MSSP provider will coordinate and work collaboratively on care coordination care activities for the MSSP member.
- CalOptima Health shall notify the CalOptima Health MSSP provider within five business days of a CalOptima Health member's disenrollment from CalOptima Health.

- CalOptima Health's MSSP providers will accept referrals from any sources including a CalOptima Health 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 Health has contracted with the California Department of Aging to host the MSSP site. MSSP is budgeted and reimbursed through monthly reconciliation of CalOptima Health members who are enrolled in the program.
- CalOptima Health will verify the Medi-Cal eligibility and plan enrollment status of each MSSP member on a monthly basis.
- CalOptima Health and its health networks will identify, refer and provide care coordination for MSSP-eligible members.
- CalOptima Health 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 and functional status.
- CalOptima Health and the CalOptima Health 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 Health member does not meet California Department of Aging (CDA) MSSP eligibility criteria 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.
- To request a State Hearing, members may write to:

  CA Department of Social Services
  State Hearing Division
  744 P. Street, Mail Station 9-17-37
  Sacramento, CA 95814

  Or fax to 916-651-5210 or 916-651-1789

  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 Health 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 his or her 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 Health 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 Health 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 Health members receiving MSSP services.
- CalOptima Health Grievance and Resolution Services (GARS) department shall manage appeals, grievances and complaints for non-related MSSP services for MSSP waiver participants, in accordance with CalOptima Health Policies CMC.9001: Member Complaint Process and HH.1102: CalOptima Health Member Complaint.

- CalOptima Health LTSS department shall be responsible for reporting MSSP appeals, grievances and complaints statistics and analysis to LTSS Quality Improvement (QI) Subcommittee on a quarterly basis.
- When a member files a timely appeal of CalOptima Health MSSP provider's decision to terminate the member from the MSSP Program or 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 Health Grievance and Appeals (GARS) department that an appeal was filed.

- CalOptima Health GARS shall provide the CalOptima Health MSSP provider with the date, place and time of the hearing.
- The CalOptima Health MSSP provider participates in a State Hearing by:

    1. Developing a written position statement in response to the appeal request
    2. Ensuring the member has a copy of the position statement
    3. Attending the hearing by telephone
    4. 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 Health GARS department.
2. CalOptima Health GARS shall notify the CalOptima Health MSSP provider of the ALJ's decision within three business days.
3. The CalOptima Health MSSP provider shall send a Letter of Notification to CalOptima Health member within three business days after notification from CalOptima Health GARS.

- CalOptima Health's GARS department shall coordinate all State Hearing actions with the CalOptima Health 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.
- CalOptima Health GARS department shall review the position statement and all health records for all other non-MSSP related services.

On a quarterly basis, the CalOptima Health MSSP provider shall submit a report of member's appeals, grievances and complaints to CalOptima Health 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 Health 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 Health 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 Health's MSSP program, please complete a Senior Select Intake Form and fax the form to CalOptima Health at **714-246-8680**. To obtain a copy of the Intake Form, please access the Providers section of CalOptima Health'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 Health'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 Health's MSSP program at **714-347-5780**.

CalOptima Health 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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

C6: LONG-TERM SUPPORT SERVICES (LTSS)

OVERVIEW

CalOptima Health administers the following Long-Term Support Services (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**).
- **IHSS:** For initial referrals only for **In-Home Supportive Services (IHSS)**.

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

CalOptima Health is responsible for determining CBAS eligibility and medical necessity criteria. Kaiser Health Foundation will determine CBAS eligibility for Kaiser Permanente members only (CalOptima Health will manage all aspects of CBAS for Kaiser Foundation members). CalOptima Health 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, or a member's case manager or personal care coordinator. CalOptima Health 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 Health and health networks, excluding members assigned to Kaiser, CalOptima Health'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

In order to qualify for CBAS, members must meet the following eligibility requirements for the CBAS program:

- Must be enrolled in CalOptima Health in the Medi-Cal or OneCare programs
- Must be at least 18 years of age or older
- Meet Nursing Facility-A (NF-A) level of care or above

Or one of the following:

- Has an organic, acquired or traumatic brain injury or chronic mental health condition
- Has moderate to severe cognitive disorder such as Alzheimer's disease or other dementia
- Has mild cognitive impairment
- Has developmental disabilities that meet Regional Center criteria and eligibility

CalOptima Health LTSS staff, a 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 Health 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 Health LTSS clinical staff shall make CBAS eligibility and medical necessity 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 and medical necessity criteria, CalOptima Health will deny the request and notify the member of the denial decision in writing through the Notice of Action or Integrated Notice of Denial that addresses members' right to file an appeal or grievance under state and federal law.

CBAS Authorization Process

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

- The completed CalOptima Health 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 initially before a member attends CBAS and every six months thereafter.

IN-HOME SUPPORTIVE SERVICES (IHSS)

The objective of the IHSS program is to allow eligible individuals to live safely at home in the least restrictive living environment.

Responsibilities of the Social Services Agency

The County of Orange Social Services Agency (SSA) is responsible for performing the following tasks related to the administration of the IHSS program:

- Assess, approve and authorize each IHSS recipient's initial and continuing need for services.
- Share assessments with CalOptima Health and its health networks' care coordination teams.
- Assign staff to participate in the care coordination teams and participate in the interdisciplinary care team meeting for CalOptima Health members who are receiving IHSS.
- Perform quality assurance activities including, but not limited to, routine case reviews, home visits and detection and reporting of suspected fraud pursuant to WIC Section 12305.71.
- Process IHSS grievances and appeals.
- Participate in administrative fair hearings.
- Assign a contact person to be responsible for oversight and supervision of the terms of the agreement in the memorandum of understanding (MOU) executed between CalOptima Health and the SSA.
- Delegate duties to PA and provide PA with referral information of all IHSS providers for the purposes of wages and benefits.
- Pursue overpayment recovery.
- Maintain IHSS advisory committee.

The SSA is responsible for verifying and processing IHSS applications. Once the IHSS application intake process is completed, the IHSS social worker shall conduct an in-home, F2F assessment and make a determination whether to approve, modify or deny the application, including determination of authorized hours.

Responsibilities of IHSS PA

IHSS PA is responsible for the following:

- IHSS provider enrollment
- Provider orientation
- Retention of enrollment documentation
- Assistance to IHSS recipients in finding IHSS-eligible providers
- Conducting criminal background checks of all potential IHSS providers
- Acting as an employer of record for IHSS individual providers serving IHSS recipients
- Performance of quality assurance activities
- Provision of administrative support for IHSS advisory committee

IHSS ENROLLMENT FOR ONECARE MEMBERS

IHSS is a OneCare benefit. Enrollment in OneCare is voluntary for IHSS members. Members may opt out of OneCare and choose to not have their Medicare benefits coordinated by CalOptima Health. However, members may not opt out of receiving their IHSS through CalOptima Health for Medi-Cal.

Eligibility for IHSS

To be eligible, a person must meet all of the following requirements:

- Be disabled, blind or age 65 years or older
- Be unable to live at home safely without help
- Meet the program's financial need requirements

IHSS Services

IHSS services include:

- Household and light cleaning, meal preparation, laundry, reasonable shopping and errands
- Personal care services, such as feeding, bathing, bowel and bladder care, dressing and other services
- Accompaniment to medical appointments and health-related services
- Paramedical care services

Members can hire and supervise their own IHSS providers. The member's social worker will authorize the types of services to be provided and the number of hours to be paid based on the needs assessment. The actual payments are issued by the State of California directly to the provider.

IHSS PROVIDER INFORMATION

Provider Reimbursement

Time sheets are mailed to IHSS care providers. IHSS members and care providers must sign and date the time sheets that are submitted by the care providers. The actual payments are then issued by the State of California directly to the care providers.

Authorization for IHSS Hours

IHSS social workers follow state regulations to determine how many IHSS hours may be authorized for each IHSS member after reviewing the following information for each member:

- The specific number of minutes state guidelines allow to complete each task required by the member
- The availability of help from other household members or other resources
- The member's medical information

Interdisciplinary Care Team (ICT)

Based on the member's identified needs, CalOptima Health or its health network providers will offer an ICT to all high-risk members to discuss a plan of care.

- CalOptima Health or health network providers shall coordinate with the SSA IHSS social worker to participate in the member's ICT conference, when appropriate.
- With the member's or member's authorized representative's consent, the SSA IHSS social worker and IHSS provider may participate in the ICT meeting.
- The member's consent and the ICT's recommendation shall be recorded in the member's electronic medical record.

Grievances and Appeals

CalOptima Health OneCare members or the member's authorized representative may file a grievance and appeal with SSA regarding any decisions concerning their IHSS services.

CONTACT INFORMATION

For more information from CalOptima Health for CBAS or IHSS services (initial referrals only), contact Long-Term Support Services at **714-246-8600**. Providers may also access CalOptima Health Policy GG.1830: In-Home Supportive Services (IHSS) Identification, Referral, and Care Coordination Process or GG.1130: Community-Based Adult Services (CBAS) Eligibility and Authorization Process available at www.caloptima.org.

In order to apply for IHSS, members may call Orange County In-Home Supportive Services at 714-825-3000, Monday through Friday, from 8 a.m. to 5 p.m. A social worker will speak to the member about the help they may need and what costs, if any, the member may be required to pay for the services. The social worker will visit the member's home and conduct a needs assessment.

CalOptima Health Policies and Procedures:

GG.1830: In-Home Supportive Services (IHSS) Identification, Referral, and Care Coordination Process

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

This section applies to the following CalOptima Health programs:

Medi-Cal

C7: PEDIATRIC PREVENTIVE SERVICES

CalOptima Health is directly responsible for paying providers for Medi-Cal services covered under the CHDP program. CalOptima Health refers to this program as the Pediatric Preventive Services (PPS) Program. CalOptima Health'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, including blood lead testing
- Health education
- Anticipatory guidance

To review the full AAP guidelines, please access the Providers section of CalOptima Health's website. CalOptima Health pays providers for PPS services on a fee-for-service basis at the same rate whether the members are in COD or enrolled in one of CalOptima Health's health networks. CalOptima Health's payment for PPS services is in addition to any payment issued by a contracted health network. In order for a provider to get an additional payment, a provider must participate in Vaccines for Children (VFC) and register for CHDP.

In order to be eligible for payment, **all providers** who bill for PPS services must **be contracted with COD or at least one of CalOptima Health's contracted health networks**. Claims submitted by a provider who is not contracted with either a health network or COD **will be denied payment** for the PPS services provided. We encourage providers to initiate a contractual relationship with COD and/or a CalOptima Health contracted health network. If you have any questions, call CalOptima Health's Provider Resource Line at **714-246-8600**.

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

PPS PROVIDER PARTICIPATION REQUIREMENTS

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

1. Providers must be contracted with COD or at least one of CalOptima Health's contracted health networks.

2. Providers must be registered with DHCS.

    a. **DHCS** — Providers and medical groups must register their NPI number with the DHCS for each service location to be registered with the CalOptima Health 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.

3. Providers must follow AAP guidelines.

4. Physicians must participate in the VFC program. Providers are not required to be CHDP certified or be Board certified to participate in the VFC program. For more information, call the VFC program at 877-243-8832 or visit their website at http://www.cdc.gov/vaccines/programs/vfc/index.html.

BILLING FOR PPS SERVICES

1. Use CMS 1500 or UB04 form to document all PPS services provided and to submit as a billing form for payment of services.
   a. If a provider is CHDP certified, call the Orange County Health Care Agency (HCA) directly at 714-834-8665 to order forms.
   b. If a provider is affiliated with a health network but is not CHDP certified, the provider should contact his or her health network's PPS coordinator to order CMS 1500 or UB04 forms.
   c. If a provider is not affiliated with a health network and is not CHDP certified, the provider should contact CalOptima Health's PPS coordinator at **714-246-8600** to obtain CMS 1500 or UB04 forms.

2. For CalOptima Health members, providers should send their CMS 1500 or UB04 forms to:

   CalOptima Health PPS Unit
   P.O. Box 11037
   Orange, CA 92856

3. For patients not eligible for CalOptima Health, **CHDP-certified providers** should send their CMS 1500 or UB04 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 Health only pays the administration fee for each vaccine supplied by the VFC Program.

CalOptima Health Policies and Procedures:

GG.1116: Pediatric Preventive Services

This section applies to the following CalOptima Health programs:

Medi-Cal

C8: PERINATAL SUPPORT SERVICES

Perinatal Support Services (PSS) are enhanced services for pregnant women provided through the CalOptima Health Bright Steps program. PSS is available to pregnant members for the duration of their pregnancy and for up to one year after birth (postpartum period). Services include, but are not limited to:

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

CalOptima Health relies on its providers to notify the Bright Steps program about pregnant women by submitting a Pregnancy Notification Report (PNR) form to CalOptima Health's Population Health Management (PHM) department within five calendar days after a member's first obstetric visit. PSS is available to all pregnant members through the CalOptima Health Bright Steps program.

1. To obtain a copy of the PNR form, please visit the Providers section of CalOptima Health's website.
2. Providers should fax the completed PNR to the CalOptima Health PHM department at **714-246-8677**.
3. To obtain more information about PSS or the Bright Steps program, call CalOptima Health's PHM department at **1-888-587-8088.**

CalOptima Health Policies and Procedures:

GG.1701: CalOptima Health Perinatal Support Services Program

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

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

- Members who have full-scope Medi-Cal benefits and 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 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, please see the OneCare Summary of Benefits located in the OneCare member section of CalOptima Health's website.

CalOptima Health contracts with VSP Vision Care to provide vision services to all CalOptima Health Medi-Cal and OneCare members

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

CalOptima Health Policies and Procedures:

GG.1111: Vision Services

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

C10: BEHAVIORAL HEALTH SERVICES

MEDI-CAL

Outpatient Behavioral Health Services

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

- Outpatient psychotherapy (individual, family 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
- Screening, Assessment, Briefing Intervention and Referral to Treatment (SABIRT)

When members are determined to have a level of impairment other than mild to moderate, they will receive services directly from the HCA Mental Health and Recovery Services (MHRS), the county behavioral health agency, 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 Drug Medi-Cal Organized Delivery System (DMC-ODS), administered by HCA.

Behavioral Health Services at Long-Term Care Facilities

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

Behavioral Health Treatment

CalOptima Health covers behavioral health treatment (BHT) services under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). BHT services include applied behavioral analysis (ABA) and other evidence-based services. A CalOptima Health Medi-Cal member may qualify for BHT services if the member:

- Is under 21 years of age
- Meets medical necessity criteria
- Has a recommendation from a licensed physician, surgeon or licensed psychologist that evidence-based BHT services are medically necessary
- Is medically stable and without need for 24-hour medical/nursing monitoring provided in a hospital or intermediate care facility for persons with intellectual disabilities

Prior Authorization

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

To request authorization for services, providers must complete and submit the following forms to CalOptima Health Utilization Management for review and decision:

- Behavioral Health Authorization Request Form (BH-ARF), fax to **714-571-2462**
- Behavioral Health Treatment Authorization Form (BHT-ARF), fax to **714-954-2300**

ONECARE

OneCare members have access to behavioral health services currently covered by Medicare and Medi-Cal. CalOptima Health directly manages the OneCare behavioral health benefits. A behavioral health provider must contract with CalOptima Health to provide OneCare behavioral health services. Available services include:

- Outpatient mental health services including, but not limited to, the following:
  - Individual and group mental health evaluation and treatment
  - Intensive Outpatient Program (IOP) services
  - Partial Hospitalization Program (PHP) services
  - Psychological testing to evaluate a mental health condition
  - Electroconvulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
- Inpatient mental health services
- SABIRT Opioid Treatment Program (OTP) services

Prior Authorization

OneCare outpatient behavioral health services do not require prior authorization except for IOP, PHP, psychological testing, ECT, TMS and OTP services. To request authorization for services, providers must complete and submit the following forms to CalOptima Health Utilization Management for review and decision:

- BH-ARF, fax to **714-571-2462**

HOW TO MAKE A BEHAVIORAL HEALTH SERVICES REFERRAL

Medi-Cal

To refer a CalOptima Health Medi-Cal member for outpatient behavioral health services, call CalOptima Health Behavioral Health at **855-877-3885** and choose the Medi-Cal option. Members will be connected to a CalOptima Health representative. The member will be screened for level of impairment to determine appropriate services. Members will either be provided with referrals to CalOptima Health-contracted behavioral health providers or directed to another level of care including MHP, the county behavioral health agency. This line is available 24/7. TTY users can call **800-735-2929**.

To refer a CalOptima Health Medi-Cal member for specialty mental health services, call the HCA MHRS Access Line at 800-723-8641. This line is available 24/7.

To have a CalOptima Health Medi-Cal member evaluated for a psychiatric emergency, which might include inpatient mental health services, call the 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 Health Behavioral Health at **855-877-3885** and choose the OneCare option**.** The member will be connected to a CalOptima Health representative to assist the member in obtaining appropriate services. The line is available 24/7. TTY users can call **800-735-2929.**

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

Both the member's PCP and behavioral health provider can make referrals to alcohol and drug abuse services. See Section D2 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 Health Provider line at **714-246-8600**

OneCare

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

- CalOptima Health Provider line at **714-246-8600**

CalOptima Health Policies and Procedures:

GG.1900: Behavioral Health Services

GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services

GG.1549: Authorization for Psychological Testing for Mental Health Conditions

MA.7020: Behavioral Health Services

This section applies to the following CalOptima Health programs:

Medi-Cal

C11: DRUG AND ALCOHOL ABUSE SERVICES

ALCOHOL AND DRUG USE SCREENING, ASSESSMENT, BRIEF INTERVENTIONS AND REFERRAL TO TREATMENT (SABIRT)

CalOptima Health offers Alcohol and Drug Use SABIRT services by providers within their scope of practice to members 11 years and older, including pregnant women. Members under 21 years of age are eligible for additional screening benefits under EPSDT.

These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, NPs, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists, and licensed marriage and family therapists. For additional details regarding the policy, please refer to the Medi-Cal Provider Manual. In providing SABIRT services, CalOptima Health must comply with all applicable laws and regulations relating to the privacy of substance use disorder (SUD) records, as well as state law concerning the right of minors over 12 years of age to consent to treatment, including, without limitation, Title 42 Code of Federal Regulations (CFR) Section 2.1 et seq., 42 CFR Section 2.14, and Family Code Section 6929.

After determining a member meets the needs for alcohol misuse services, an appropriate referral can be made to community health care and social service programs with specialty treatment programs.

For more information regarding SABIRT, visit the Providers section on CalOptima Health's website.

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

Both the member's PCP and behavioral health provider can make referrals to alcohol and drug abuse services. To receive member information related to substance abuse or behavioral health services covered by CalOptima Health, please contact CalOptima Health Behavioral Health at **855-877-3885**. For information regarding services provided by other agencies, please refer to D2.

CalOptima Health Policies and Procedures:

GG.1100: Alcohol and Substance Use Disorder Treatment Services

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

C12: TELEHEALTH SERVICES

CalOptima Health and its health networks shall ensure that covered services provided through telehealth are rendered by qualified providers who meet appropriate licensing and regulatory requirements**.** Qualified providers may provide Medi-Cal covered services to members through telehealth in compliance with applicable statutory, regulatory and contractual requirements, as well as Department of Health Care Services' (DHCS) guidance. CalOptima Health and health networks may use telehealth providers when they are unable to meet time or distance standards and to increase the network capacity when submitting Alternative Access Standard (AAS) requests.

TELEHEALTH REQUIREMENTS

Existing covered services, identified by Current Procedural Terminology 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via telehealth only if all the following criteria are satisfied:

1. The treating provider believes the covered services are clinically appropriate for telehealth delivery using evidence-based medicine and best clinical judgment.
2. The member has provided verbal or written consent.
3. Medical record documentation substantiates that the covered services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS codes. Providers are not required to document a barrier to an in-person visit (WIC section 14132.72(d)) or document the cost-effectiveness of telehealth to be reimbursed for covered services.
4. The covered services meet all state and federal laws regarding confidentiality of health care information and a member's right to their own medical information.

All providers, except Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and tribal health providers (THPs), are allowed to be reimbursed for consultations provided via telehealth.

After January 1, 2024, providers must furnish covered services via audio-only and video synchronous interactions to preserve member choice. Also, to preserve a member's right to access covered services in person, a provider furnishing services through a video or audio synchronous interaction must do one of the following:

1. Offer those same services via in-person, face-to-face contact.
2. Arrange for a referral to, and the facilitation of, in-person care that does not require a member to independently contact a different provider.

Providers must inform members prior to the initial delivery of covered services via telehealth about the use of telehealth and obtain verbal or written consent from members for the use of telehealth as an acceptable mode of delivering services. Providers need to document the member's consent in their medical record prior to the initial delivery of services and make that consent available to DHCS upon request.

In addition to documenting consent, providers are also required to explain the following:

1. The member's right to access covered services in person.

2. The use of telehealth is voluntary and consent for telehealth can be withdrawn at any time by the member without affecting their ability to access Medi-Cal covered services in the future.
3. The availability of non-medical transportation to in-person visits.
4. The potential limitations or risks related to receiving covered services through telehealth compared with an in-person visit, if applicable.

DHCS has created model member consent language for managed care plans (MCPs) and providers to use. Members may be established as new patients by providers via telehealth in the following ways:

1. Via synchronous video telehealth visits.
2. Via audio-only synchronous interaction only if one or more of the following criteria applies:
   a. The visit is related to sensitive services, which is defined in Civil Code section 56.06(n) as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care and intimate partner violence, and includes services described in Family Code sections 6924–6930 and HSC sections 121020 and 124260, obtained by a member at or above the minimum age specified for consenting to the service specified in the section.
   b. The member requests an audio-only modality.
   c. The member attests they do not have access to video.
3. FQHCs — including tribal FQHCs — and RHCs may establish new patient relationships through an asynchronous store-and-forward modality, as defined in BPC section 2290.5(a) if the visit meets all the following conditions:
   a. The member is physically present at a provider's site or at an intermittent site of the provider at the time the covered service is performed.
   b. The individual who creates the patient's medical records at the originating site is an employee or subcontractor of the provider or another person lawfully authorized by the provider to create a patient medical record.
   c. The provider determines that the billing provider can meet the applicable standard of care.
   d. A member who receives covered services via telehealth must otherwise be eligible to receive in-person services from that provider.

To ensure proper payment and record of covered services provided via telehealth, all providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications.

CalOptima Health Policies and Procedures:

GG.1665: Telehealth and Other Technology-Enabled Services

This section applies to the following CalOptima Health programs:

Medi-Cal

C13: DOULA SERVICES

Doula services are available to members through CalOptima Health's Medi-Cal program. Doulas are birth workers who provide health education, advocacy and physical, emotional and non-medical support for pregnant and postpartum persons before, during and after childbirth, including support during miscarriages, stillbirths and abortions. Doulas may also offer various types of support, including health navigation, lactation support, development of a birth plan and linkages to community-based resources. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

PROVIDER REQUIREMENTS

Effective January 1, 2023, CalOptima Health is required to provide doula services for prenatal, perinatal and postpartum members. Doula services can be provided virtually or in person with locations in any setting including, but not limited to, homes, office visits, hospitals or alternative birth centers.

Covered Services

1. DHCS has provided a standing recommendation for doula services, which includes the following authorizations:
    a. One initial visit
    b. Up to eight additional visits are provided in any combination of prenatal and postpartum visits.
    c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
    d. Up to two extended three-hour postpartum visits after the end of a pregnancy
2. Members may receive up to nine additional postpartum visits. These additional visits require a recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice.
3. All visits are limited to one per day per member.
4. Only one doula can bill for a visit provided to the same member on the same day, excluding labor and delivery.
5. One prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion or miscarriage support.
6. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula.
7. The extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation. The extended postpartum visits are billed in 15-minute increments, up to three hours, and up to two visits per pregnancy per individual provided on separate days.
8. If a member requests or requires pregnancy-related services that are available through Medi-Cal, then the doula should work with the member's PCP, if that information is available, or work with CalOptima Health to refer the member to a provider who is able to render the service. These Medi-Cal services include, but are not limited to:
    a. Behavioral health services
    b. Belly binding after cesarean section by clinical personnel
    c. Clinical case coordination
    d. Health care services related to pregnancy, birth and the postpartum period
    e. Childbirth education group classes

f. Comprehensive health education including orientation, assessment and planning (Comprehensive Perinatal Services Program services)
g. Hypnotherapy (non-specialty mental health service)
h. Lactation consulting, group classes and supplies
i. Nutrition services (assessment, counseling and development of care plan)
j. Transportation
k. Medically appropriate Community Supports services

Non-Covered Services

Doula services do not include diagnosis of medical conditions, provision of medical advice or any type of clinical assessment, exam or procedure. The following services are not covered under Medi-Cal or as doula services:

1. Belly binding (traditional/ceremonial)
2. Birthing ceremonies (i.e., sealing, closing the bones, etc.)
3. Group classes on babywearing
4. Massage (maternal or infant)
5. Photography
6. Placenta encapsulation
7. Shopping
8. Vaginal steams
9. Yoga

Documentation Requirements

1. In order to close maternity care disparities and improve birth outcomes and children's preventive care, DHCS has determined that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from doula services. Doula services may only be provided during pregnancy; during labor and delivery, miscarriage, and abortion; and within one year of the end of a beneficiary's pregnancy. Doulas who use this standing recommendation for their members should note the standing recommendation in their records. This standing recommendation authorizes the following services:
    a. One initial visit
    b. Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits
    c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
    d. Up to two extended three-hour postpartum visits after the end of a pregnancy
2. This standing recommendation does not authorize additional postpartum visits beyond the eight visits that may be provided during either the prenatal or postpartum period. Members may receive up to nine additional postpartum visits with an additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice.
3. CalOptima Health will ensure doulas document the dates, time and duration of services provided to members.
4. Documentation must also reflect information on the service provided and the length of time, in minutes, spent with the member that day.
5. Documentation should be integrated into the member's medical record and available for encounter data reporting.
6. The doula's NPI number should be included in the documentation.
7. Documentation must be accessible to CalOptima Health and DHCS upon request.

Doula Provider Requirements and Qualifications

1. All doulas must be at least 18 years old, possess an adult/infant CPR certification and have completed HIPPA training.
2. Doulas must qualify by meeting either the training or experience pathway as described below:
    a. Training Pathway:
        - Complete a minimum of 16 hours of training in the following areas:
            i. Lactation support
            ii. Childbirth education
            iii. Foundations of anatomy of pregnancy and childbirth
            iv. Nonmedical comfort measures, prenatal support and labor support techniques
            v. Developing a community resource list
        - Provide support at a minimum of three births
    b. Experience Pathway:
        - Complete all of the following:
            i. At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
            ii. Attestation to skills in prenatal, labor and postpartum care as demonstrated by the following:
                - Three written client testimonial letters or professional letters of recommendation from a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization or an enrolled doula. “Enrolled doula” means a doula enrolled either through DHCS or through an MCP.

3. CalOptima Health and its health networks will ensure doulas complete three hours of continuing education in maternal, perinatal and/or infant care every three years. Doulas must maintain evidence of completed training to be made available to DHCS upon request.

Provider Enrollment

Providers, including those who will operate as providers of doula services, are required to enroll as Medi-Cal providers.

Billing, Claims and Payments

Claims for doula services must be submitted with allowable Current Procedural Terminology (CPT) codes as outlined in the DHCS Medi-Cal Provider Manual. Doulas cannot double bill for doula services that are duplicative to services that are reimbursed through other benefits.

A diagnosis code is required for encounter data. While a doula should not be diagnosing a patient, they must submit their claims with a diagnosis that is relevant to the service they are providing. The following ICD-10-CM Codes are HIPAA compliant:

- Z33.1 Pregnant state, incidental
- Z33.2 Encounter for elective termination of pregnancy
- Z39.2 Encounter for routine postpartum follow-up
- O02.1 Missed abortion
- O03.4 Incomplete spontaneous abortion without complication

The following codes may be used for all services when submitting claims:

Prenatal and Postpartum Visits

- Z1032 – Extended initial visit 90 minutes
- Z1034 – Prenatal visit
- Z1038 – Postpartum visit
- T1032 – Extended postpartum visit

Labor and Delivery Support

- CPT 59409 – Doula support during vaginal delivery only
- CPT 59612 – Doula support during vaginal delivery after previous cesarean section
- CPT 59620 – Doula support during cesarean section

Abortion or Miscarriage Support

- HCPCS T1033 – Doula support during or after miscarriage
- CPT 59840 – Doula support during or after abortion

CalOptima Health Policies and Procedures:

GG.1707: Doula Services

This section applies to the following CalOptima Health programs:

Medi-Cal

C14: COMMUNITY HEALTH WORKER SERVICES

Community health worker (CHW) services may assist with a variety of concerns impacting CalOptima Health members, including, but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and the need for preventive services. More specifically, CHW services can help members receive appropriate services related to the following types of care: perinatal, preventive, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury and domestic violence and/or other violence prevention services. CHWs provide culturally appropriate care tailored to the communities being served and are often members of the community they are serving.

CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below. Through their community connection and engagement, CHWs will advance California Advancing and Innovating Medi-Cal (CalAIM) efforts in providing equitable health care through culturally competent services and further promote CalOptima Health's contractual obligations to meet the Department of Health Care Services' (DHCS) broader Population Health Management (PHM) standards.

CHW PROVIDER REQUIREMENTS AND QUALIFICATIONS

CHWs must have lived experience that aligns with and provides a connection between the CHW and the member or population being served. This may include but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services. Supervising providers (the organizations employing or otherwise overseeing the CHWs with which CalOptima Health contracts, as described below) are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising providers must maintain evidence of this experience.

CHWs must demonstrate, and supervising providers must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the supervising provider:

- Certificate Pathway: CHWs demonstrating qualifications through the certificate pathway must provide proof of completion of at least one of the following certificates:
    - CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social determinants of health (SDOH), as determined by the supervising provider. Certificate programs must also include field experience as a requirement.
    - A CHW certificate allows a CHW to provide all covered CHW services.

- Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) certificate issued by the Health Alliance for

Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute is required. A VPP certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a general certificate.

- Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the supervising provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a member.

CHWs must complete a minimum of six hours of additional relevant training annually. The supervising provider must maintain evidence of this training. Supervising providers may provide and/or require additional training, as identified by the supervising provider.

Supervisor Provider

A supervising provider is an organization employing or otherwise overseeing the CHW with which CalOptima Health contracts. The supervising provider ensures that CHWs meet the qualifications listed below, oversees CHWs and the services delivered to CalOptima Health members, and submits claims for services provided by CHWs. The supervising provider must be enrolled with Medi-Cal as a licensed provider, hospital, outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO).

The supervising provider does not need to be the same entity as the provider who made the referral for CHW services. Supervising providers do not need to be physically present at the location where CHWs provide services to members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the supervising provider. However, the supervising provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.

Supervising providers must provide direct or indirect oversight to CHWs. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

MEMBER ELIGIBILITY CRITERIA FOR CHW SERVICES

CHW services require a written recommendation submitted to CalOptima Health by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses and pharmacists.

The recommending licensed provider must ensure that a member meets eligibility criteria before recommending CHW services. CHW services are considered medically necessary for members with one or more chronic health (including behavioral health) conditions or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social

needs, and/or who would benefit from preventive services. The recommending provider must determine whether a member meets the eligibility criteria for CHW services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- The presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use and/or drug misuse.
- Results of an SDOH screening that indicates unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department (ED) within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed a need for support in health system navigation or resource coordination services.
- Need for recommended preventive services, including updated immunizations, annual dental visits, and well-child care visits for children.

CHW violence prevention services are available to members who meet any of the following circumstances as determined by a licensed practitioner:

- The member has been violently injured due to community violence.
- The member is at significant risk of experiencing violent injury due to community violence.
- The member has experienced chronic exposure to community violence.

DOCUMENTATION REQUIREMENTS

CHWs are required to document the dates and time/duration of services provided to members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. Documentation must be accessible to the supervising provider upon their request. Documentation should be integrated into the member's medical record and available for encounter data reporting. The CHW's National Provider Identifier (NPI) number should be included in the documentation.

PLAN OF CARE

For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW supervising provider. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider. CHWs may participate in the development of the plan of care and may take a lead role in drafting it if done in collaboration with the member's care team and/or other providers referenced in this section. The plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition.
- Include a list of other health care professionals providing treatment for the condition or barrier.

- Contain written objectives that specifically address the recipient's condition or barrier affecting their health.
- List the specific services required for meeting the written objectives.
- Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.

A licensed provider must review the member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition, providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

COVERED CHW SERVICES

CHW services can be provided as individual or group sessions. There are no service location limits and virtual or in-person services can be provided in any setting including, but not limited to, outpatient clinics, hospitals, homes or community settings. There are no service location limits. Supervising providers should refer to the telehealth section in Part 2 of the DHCS Provider Manual for guidance regarding providing services via telehealth. Covered services include:

Health Education: Promoting a member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a member's health or ability to self-manage their health conditions.

Health Navigation: Providing information, training, referrals or support to assist members in accessing health care, understanding the health care delivery system or engaging in their own care. This includes connecting members to community resources necessary to promote health, addressing barriers to care (including connecting to medical translation/interpretation or transportation services) or addressing health-related social needs. Under health navigation, CHWs can also:

- Serve as a cultural liaison or assist a licensed health care provider to participate in the development of a plan of care, as part of a health care team.
- Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services.
- Help a member enroll or maintain enrollment in government or other assistance programs that are related to improving their health if such navigation services are provided pursuant to a plan of care.

Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a member with connecting to appropriate services to improve their health.

Individual Support or Advocacy: Assisting a member in preventing the onset or exacerbation of a health condition or preventing injury or violence.

NON-COVERED CHW SERVICES

- Clinical case management/care management that requires a license
- Childcare
- Chore services, including shopping and cooking meals
- Companion services
- Employment services

- Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
- Delivery of medication, medical equipment or medical supply
- Personal care services/homemaker services
- Respite care
- Services that duplicate another covered Medi-Cal service already being provided to a member
- Socialization
- Coordinating and assisting with transportation
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license
- Peer support services

CHWs may provide services to members with mental health and/or substance use disorders. CHW services do not include peer support services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System and Specialty Mental Health Services programs. CHW services are distinct and separate from peer support services.

PROVIDER ENROLLMENT

Providers, including those who will operate as supervising providers, are required to enroll as Medi-Cal providers if there is a state-level enrollment pathway for them to do so. However, some supervising providers may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. These providers must be vetted by CalOptima Health to participate as supervising providers, as described below. Supervising providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS' Provider Enrollment Division.

To include a supervising provider in their networks when there is no state-level Medi-Cal enrollment pathway, CalOptima Health is required to vet the qualifications of the provider or provider organization to ensure they can meet the standards and capabilities required to be a supervising provider.

CHWs are not required to enroll as Medi-Cal providers and are therefore not subject to the requirements outlined in All Plan Letter (APL) 22-013. CHWs are to adhere to the requirements outlined in CalOptima Health Policy GG.1213: Community Health Worker Services.

BILLING, CLAIMS AND PAYMENTS

CHW services must be reimbursed through a CHW supervising provider in accordance with its provider contract, unless reimbursed directly through CalOptima Health if the CHW is a Medi-Cal-enrolled provider. Since CHW services are preventive, CalOptima Health will not require prior authorization. However, quantity limits can be applied based on goals detailed in the plan of care. Claims for CHW services must be submitted by the supervising provider with allowable Current Procedural Terminology (CPT) codes as outlined in the Medi-Cal Provider Manual. All providers and subcontractors must not double bill for CHW services that are duplicative to services reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit. Therefore, CalOptima Health will ensure that providers do not bill for CHW services and ECM for the same member for the same period. Tribal clinics may bill CalOptima Health for CHW services at the fee-for-service rates using the CPT codes as outlined in the Provider Manual.

CalOptima Health Policies and Procedures:

GG.1213: Community Health Worker Services

This section applies to the following CalOptima Health programs:

Medi-Cal

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 Health 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**.

This section applies to the following CalOptima Health programs:

Medi-Cal

D2: DRUG AND ALCOHOL ABUSE SERVICES

Alcohol and drug abuse services are a covered benefit for CalOptima Health Medi-Cal members, although these services are available through the DMC-ODS administered by the HCA.

DMC-ODS provides SUD treatment services to all eligible Med-Cal beneficiaries who reside in Orange County.

Services include outpatient drug-free, intensive outpatient treatment, residential treatment, recovery services, withdrawal management, narcotic treatment program/opioid treatment program and medication-assisted treatment. 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.

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

Both the member's PCP and behavioral health provider can make referrals to alcohol and drug abuse services. To receive member information related to substance abuse or behavioral health services covered by CalOptima Health, contact CalOptima Health Behavioral Health at **855-877-3885**. To access county DMC-ODS services, Medi-Cal members can call the county Beneficiary Access Line at 800-723-8641, 24/7. For more information about the DMC-ODS plan, individuals can call OC Links at 855-625-4657, 24/7.

CalOptima Health Policies and Procedures:

GG.1100: Alcohol and Substance Use Disorder Treatment Services

This section applies to the following CalOptima Health programs:

Medi-Cal

D3: WHOLE-CHILD MODEL (WCM)

The WCM program helps children up to age 21 eligible for California Children's Services (CCS) and their families get better care coordination, access to care and improved health results. Prior to July 1, 2019, children with CCS-eligible diagnoses were enrolled in and received care from both the county CCS program for their CCS condition and CalOptima Health for their non-CCS conditions.

Senate Bill (SB) 586 authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated counties, including Orange County.

CCS SERVICES PROVIDED UNDER THE WCM PROGRAM

In Orange County, CalOptima Health and its delegated health networks are responsible for coordinating and authorizing CCS services consistent with its current processes.

CCS services are provided by CCS-paneled and CCS-approved providers. If a specialist is not a part of CalOptima Health's network and/or is located outside the county, CalOptima Health or one of its health networks will be responsible for coordinating and approving those services, as appropriate.

CCS services for non-CalOptima Health members will remain the responsibility of the local CCS program administered by the Orange County Health Care Agency (HCA).

The local CCS program will retain responsibility for determining CCS program eligibility. Note that CCS eligibility is separate from Medi-Cal eligibility. Members will need to continue to work with the County of Orange Social Services Agency regarding Medi-Cal eligibility.

IDENTIFYING PATIENTS POTENTIALLY ELIGIBLE FOR CCS SERVICES

To be eligible for CCS, CalOptima Health 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
- Craniofacial anomalies
- Myelomeningocele

- 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 CCS Eligibility page on DHCS' website or the California Children's Services page on the County of Orange website.

If the condition needing treatment is for a new, potentially CCS-eligible condition, the provider should submit a completed CCS Service Authorization Request (SAR) and pertinent medical reports to the member's health network (including CalOptima Health Direct [COD] and CalOptima Health Community Network [CCN]).

For CalOptima Health members, SARs will be processed for medical eligibility determination only. Authorization for treatment must be directed to the member's health network (including COD and CCN).

HELPFUL INFORMATION FOR THE AUTHORIZATION PROCESS

Requests for COD and CCN members for services requiring prior authorization should be submitted to CalOptima Health's Utilization Management department by fax or through the CalOptima Health Link portal.

Health Networks

- Requests for treatment requiring prior authorization should be submitted to the member's health network.
- When making the referral, please keep in mind that the child must use a CCS-paneled provider to receive CCS-covered services.
- CCS benefits remain the same under WCM. Most CCS benefits will be provided through CalOptima Health and its health networks.
- For questions regarding the Medical Therapy Program (MTP) and all CCS services for non-Medi-Cal members, please contact the local CCS program administered by HCA at **714-347-0300**.
- The Pediatric Palliative Care Waiver program ended on December 31, 2018. Beginning January 1, 2019, children enrolled in CalOptima Health receive palliative care services through CalOptima Health or their health network.

CONTINUITY OF CARE

CalOptima Health and its delegated health networks will provide continuity of care for WCM members for up to 12 months. Continuity of care means that a member can continue receiving care from their CCS-paneled providers if certain criteria are met:

- Member has an existing relationship with the provider.
- Provider accepts CalOptima Health's (or health network's) reimbursement rate or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher unless otherwise agreed.
- Provider has no quality and credentialing issues.

Continuity of care applies to specialists, special care centers and custom Durable Medical Equipment (DME) providers. In addition, continuity of care may also apply to the CCS public health nurse, if available. There is also a provision for continued access to medication until the provider has discontinued the medication or it is no longer needed.

If you are a CCS-paneled provider currently providing services to a CalOptima Health member who is CCS-eligible, you may request continuity of care on the member's behalf. Contact CalOptima Health Customer Service at **714-246-8500** for more information.

If the WCM member has an established relationship with a custom DME provider, CalOptima Health and its delegated health networks will provide access to that DME provider for up to 12 months. Continuity of care criteria is met if the custom DME:

- Is uniquely constructed or substantially modified solely for the use of the WCM transitioning member
- Is made to order or adapted to meet the specific needs of the WCM transitioning member
- Is uniquely constructed, adapted or modified such that it precludes use by another person and cannot be grouped with other items meant for the same use for pricing purposes

Continuity of care may be extended beyond 12 months for custom DME still under warranty and deemed medically necessary.

HOW TO BECOME A CCS PROVIDER

- In order to become a CCS provider, submit a CCS panel application online at Children's Medical Services.
- Providers may track their application status online with a unique tracking number. In addition, providers will receive immediate online approval or a request for any additional documentation necessary to process their pending applications.

Providers can find CCS program participation requirements by provider type on this page on DHCS' website: https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Details about how to become a CCS-paneled provider are on this page of DHCS' website: http://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

All CCS providers are encouraged to contact CalOptima Health and its delegated health networks about contracting. Please contact the CalOptima Health Provider Relations department to speak to a representative at **714-246-8600**.

CLAIMS INFORMATION

Claims for WCM services provided on and after July 1, 2019, should be submitted to the member's health network (including COD or CCN), except for the carved-out benefits, such as MTP-related services, which will continue to be authorized by the local CCS program.

For claims directed to CalOptima Health, both electronic and hard copy formats are accepted.

For questions regarding the submission of claims, contact CalOptima Health's Claims department at 714-246-8600.

Electronic claims submission: CalOptima Health has a contract with a clearinghouse to receive electronic data interchange (EDI) claims. There is no cost to you for services provided by our clearinghouse. To register and submit electronically, contact:

Office Ally
866-575-4120
www.officeally.com

Payment for CCS Services: CalOptima Health and its health networks are required to pay CCS-paneled providers at rates that are at least equal to CCS fee-for-service rates, unless the provider enters into an agreement on an alternative payment methodology mutually agreed upon.

DENIED CLAIMS — PRIOR AUTHORIZATIONS

- To request services for a member, the provider must submit a complete authorization request as outlined in Section F1: Obtaining Authorization for Medical Services.

FOR MORE INFORMATION ON WCM

More information about CalOptima Health's WCM program is available at https://www.caloptima.org/en/About/CurrentInitiatives/WholeChildModel.aspx or by calling **714-347-0300** (CalOptima Health providers only).

Health Network	Phone Number
AltaMed Medical Group	855-848-5252
AMVI Care Health Network	888-747-2684
CalOptima Community Network	**714-246-8600**
Children's Hospital Orange County Health Alliance	800-387-1103
Family Choice Health Network	800-611-0111
Heritage Provider Network – Regal Medical Group	800-747-2362
Noble Mid-Orange County	888-880-8811
Optum	888-656-7523
Prospect Medical Group	800-708-3230
United Care Medical Group	877-225-6784

CalOptima Policies and Procedures:
GG.1101: California Children's Services

This section applies to the following CalOptima Health programs:

Medi-Cal

D4: DENTAL SERVICES

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

- Members who have full-scope Medi-Cal benefits and are under the age of 21
- Members who are residents of an 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 Medi-Cal Dental Program website at https://dental.dhcs.ca.gov/.

The current dental benefit is administered by the Medi-Cal Dental Program and **not by CalOptima Health or its health networks**. CalOptima Health's health networks and COD 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 will be able to receive dental benefits as part of their OneCare benefits.

CalOptima Health providers can play a critical role in identifying dental-related issues and in referring members to appropriate dental providers. Most dental diseases 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, call Medi-Cal Dental Program at 800-322-6384 (TDD/TTY 800-735-2922) or go to the Medi-Cal Dental Program website at https://dental.dhcs.ca.gov/.
2. All children with an active infection**,** pain or severe problems should be referred to the Medi-Cal Dental 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 the age of 3 should be referred to a dentist. Children over the age of 3 should have the benefit of definitive dental diagnosis and remedial treatment and should be seen by a dentist at least annually.

CalOptima Health Policies and Procedures:

GG.1504: Dental Services

This section applies to the following CalOptima Health programs:

Medi-Cal

D5: HOME AND COMMUNITY-BASED SERVICES REFERRALS

Some CalOptima Health 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 Health 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 Health Case Management department at **714-246-8686**.

This section applies to the following CalOptima Health programs:

Medi-Cal

D6: 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 under the age of 18 who has or may have a developmental disability is entitled to receive an assessment to determine eligibility.
- To be eligible for services, a person must have a disability that is substantially handicapping, i.e., intellectual disability, epilepsy, cerebral palsy, autism and disabling conditions found to be closely related to intellectual/cognitive disabling or that require treatment similar to individuals with intellectual disabilities. The RCOC does not cover handicapping conditions that are solely physical, psychiatric or a learning disability.
- 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 on individual program plans and may include:

- Prenatal diagnostic evaluation
- Early intervention services (from birth up to 36 months)
- Therapy services
- Respite care services
- Childcare services
- Adult day program services (employment and community-based activities)
- Transportation services
- Residential services (group homes, independent and supported living services)
- Psychological counseling and behavioral services
- Medical and dental services
- Equipment and supplies
- Social and recreational services
- Coordinated family support services

COORDINATION OF MEMBER CARE

CalOptima Health or the member's health network will designate a community liaison or case manager to serve as a liaison to RCOC to help coordinate care, as needed.

HOW TO REFER A MEMBER TO THE RCOC

Providers who believe that a patient should be referred to the RCOC should contact their offices by calling 714-796-5100. To obtain more information, visit RCOC's website at: http://www.rcocdd.com/.

CalOptima Health Policies and Procedures:

GG.1302a: Coordination of Care for Regional Center of Orange County

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

E1: VERIFYING MEMBER ELIGIBILITY

Except for emergency services, providers rendering covered services to any CalOptima Health member should first verify eligibility prior to rendering the service. CalOptima Health 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 Health's Eligibility Verification System — CalOptima Health maintains the CalOptima Health Provider Portal to verify member eligibility.

CalOptima Health's Eligibility Verification Systems	Description
CalOptima Health Provider Portal	CalOptima Health allows providers to obtain eligibility information online through CalOptima Health Provider Portal. CalOptima Health Provider Portal provides the member's assigned health network and primary care provider. Providers must be registered with CalOptima Health to utilize this service. Providers may register via the Providers tab on the CalOptima Health website.

State Eligibility Verification Systems	Description
Automated Eligibility Verification Systems (AEVS)	This system returns a Medi-Cal Eligibility Verification Confirmation number (EVC). The Automated Eligibility Verification System (AEVS) is accessible by calling 800-456-2387.
Point of Service (POS) Device	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.
Medi-Cal Website	Providers may verify Medi-Cal eligibility on the Medi-Cal website at: www.medi-cal.ca.gov/ 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.

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 Health or its health networks.

CalOptima Health Policies and Procedures:

DD.2003: Member Identification and Eligibility Verification

This section applies to the following CalOptima Health programs:

Medi-Cal

E2: MEDI-CAL RECIPIENTS NOT ENROLLED IN CALOPTIMA HEALTH

The Department of Health Care Services (DHCS) enrolls most, but not all, Medi-Cal beneficiaries residing in Orange County into CalOptima Health. 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 Health. 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 HEALTH

Providers can identify Medi-Cal beneficiaries enrolled in CalOptima Health 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 Health** — For these recipients the state systems will reference the beneficiary as "Medi-Cal Eligible" and indicate "Health Plan Member: CalOptima Health." The state system will also display "Health Care Plan: CalOptima Health" 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 Health** — 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 Health 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 Health, 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 Health programs:

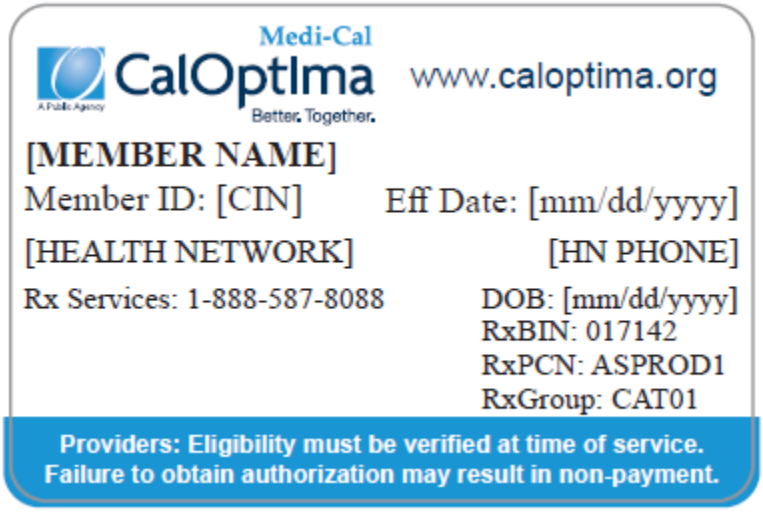
Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

E3: CALOPTIMA HEALTH'S MEDI-CAL, ONECARE (HMO D-SNP)

CalOptima Health Medi-Cal ID Card: CalOptima Health issues each Medi-Cal member an identification card upon enrollment. The CalOptima Health 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 Health.

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 Health Medi-Cal ID Card



Sample Medi-Cal BIC Card

IMPORTANT TIPS ABOUT THE MEMBER ID CARD

The CalOptima Health 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. CalOptima Health Provider Resource Line: **714-246-8600**
    c. CalOptima Health Customer Service Line (members only): **888-587-8088** or TTY **711**

Upon presentation of the CalOptima Health member ID card, a provider can verify the member's eligibility by using the CalOptima Health Provider Portal located in the Providers section of CalOptima Health's website.. 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 Health OneCare Member ID Card

IMPORTANT TIPS ABOUT THE MEMBER ID CARD

The OneCare member ID card contains the following information:

- Front of the card:
  a. Member's name
  b. Member's ID number
  c. Member's date of birth
  d. Member's effective date
  e. Name of member's PCP
  f. Phone number of member's PCP
  g. Member's health network
  h. Phone number of member's health network
  i. Member's pharmacy information (RxBIN, RxPCN and RxGroup)

- Back of the card:
  a. Important contact numbers
  b. Claim submission information

Upon presentation of the OneCare member ID card, a provider can verify the member's eligibility by using CalOptima Health Provider Portal located on CalOptima Health's website. For more information on verifying a member's eligibility, see **Section E1: Verifying Member Eligibility**.

This section applies to the following CalOptima Health programs:

Medi-Cal

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 Health 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 D-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 members are not required to meet their share of cost to access Medicare benefits**. For a list of OneCare (HMO D-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/
2. By calling the Automated Eligibility Verification System (AVES) at **800-456-2387**
3. By using a Point of Service (POS) device

This section applies to the following CalOptima Health programs:

Medi-Cal

E5: SHARE OF COST FOR LONG-TERM CARE (LTC) SERVICES

Some CalOptima Health 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 Health 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 Health. **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 Health for the remainder of the month. **Once the member becomes eligible for CalOptima Health for the month, all CalOptima Health Direct prior authorization guidelines apply.**

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

Example: LTC Facility Daily Rate ($2,500) – Share of Cost ($450) = Bill CalOptima Health ($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 Health operates in accordance with established Medi-Cal guidelines.

This section applies to the following CalOptima Health programs:

Medi-Cal

F1: OBTAINING AUTHORIZATION FOR MEDICAL SERVICES

CalOptima Health and its health networks perform utilization management (UM) 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 Health and its health networks conduct prospective reviews 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 of care and reflect the application of approved review criteria and guidelines. Physician review and determination are required for all final denial or modified decisions for requested medical services. The denial of a pharmacy prior authorization may be reviewed by a qualified physician or pharmacist. Members with both Medicare and Medi-Cal are an exception to the preauthorization 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 Health Direct (COD), the provider will submit the request for authorization to the CalOptima Health Utilization Management department by mail, fax and 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 Health. For potential retroactive eligibility, the provider should check the Medi-Cal eligibility system on a monthly basis. 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 and follow the health network's specific instructions for requesting authorization. For CalOptima Health network contact information, see **Section: B1: CalOptima Health Department and Program Contact Information**.

   If the member is enrolled in COD or CCN, see steps 3–5 below.

3. For COD and CCN members, urgent, retro and routine authorizations may be requested through CalOptima Health's Provider Portal, located in the Providers section of CalOptima Health's website at www.caloptima.org. If a provider is unable to submit the request online, the provider should complete the Authorization Request Form (ARF) and submit it to CalOptima Health's Utilization Management department. A copy of the ARF is on CalOptima Health's website at: www.caloptima.org.

   In completing the ARF or submitting online, please be sure to supply the following information for the requested service:
   a. 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 ARF, the provider should submit the ARF to the CalOptima Health Utilization Management department.
   a. For urgent requests, fax to **714-338-3137**. The urgent 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 Health or the health network will 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 a request within 30 minutes of receipt of the request or it will be deemed approved.

4. **Concurrent review of authorization for treatment regimen already in place:** Within 24 hours of the decision, consistent with the 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 of receipt of request in accordance with Health and Safety Code Section 1367.01(h)(1).

6. **Pharmaceuticals:** 24 hours on all drugs that require prior authorization in accordance with Section 1927 (d) of the SSA.

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, out-of-network or 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 Health 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 Health 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 Health 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 Health or the member's health network may extend the 72-hour time period by up to 14 calendar days if the member requests an extension or if CalOptima Health or the member's health network justifies to 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 Health Policies and Procedures:

GG.1500: Authorization Instructions for CalOptima Health Direct Providers

GG.1508: Authorization and Processing of Referrals

This section applies to the following CalOptima Health programs:

OneCare

F1: OBTAINING AUTHORIZATION FOR MEDICAL SERVICES

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

- **Authorization of Medicare Services**: **OneCare Health Network Responsibility** — In general, all Medicare-covered services requiring authorization are reviewed by the member's OneCare health network. OneCare health networks authorize specialty consultations, medical treatments, hospital admissions, skilled nursing admissions, hospice admissions and certain ancillary services. Please contact the member's OneCare 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 Responsibility** — OneCare members may use their Medi-Cal benefits when they exhaust Medicare coverage of a specific service or may require services only covered by Medi-Cal. OneCare, and not the members' health network, is responsible for authorizing referrals for Medi-Cal-covered services. For more information on Medi-Cal-covered benefits for OneCare members, please visit the Members section of the CalOptima Health website.
- **Referral Authorization Determination Time Frames** — Basic authorization processing turnaround times for OneCare reflect Medicare's required time frames. Turnaround time frames start from the date or time that OneCare or the member's health network receives the authorization request. The turnaround times are as follows:

    - Routine authorizations — 14 calendar days from the receipt of request
    - Expedited authorizations — 72 hours from the receipt of request
    - Retroactive authorizations — 30 calendar days from the receipt of request

- **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'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 they are submitting the request on behalf of the member, but that they do not concur that the requested service is medically necessary.

4. The provider should check the member's eligibility to verify the member's OneCare health network. The provider should select a referral provider from the member's OneCare 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 health network**, the provider should complete the OneCare health network's authorization request form and submit the form to the health network. For OneCare health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.

   If the service needs to be authorized by OneCare (Medi-Cal) — The provider should submit the request via the CalOptima Health Provider Portal, as this may result in an automatic authorization and a timelier response.

   If the provider is unable to submit the request online, please fax the request to OneCare's Utilization Management department:

   a. For urgent requests, 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 or out-of-network providers must be approved by the appropriate utilization management entity (i.e., the OneCare health network or OneCare, as appropriate).
7. The OneCare health network or OneCare 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 health network or OneCare renders a decision, the medical group will notify the referring provider and member and provide the referral authorization letter.
9. If OneCare or the member's OneCare 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 Health Policies and Procedures:

MA.6042 Integrated Organization Determinations

This section applies to the following CalOptima Health 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 COD.

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
- 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 check the Provider section of the CalOptima Health website at: www.caloptima.org/en/ForProviders/ClaimsAndEligibility/PriorAuthorizations.aspx or call the CalOptima Health Provider Resource Line at **714-246-8600**.

CalOptima Health Policies and Procedures:

GG.1508: Authorization and Processing of Referrals

GG.1500: Authorization Guidelines for CalOptima Health Direct Providers

This section applies to the following CalOptima Health programs:

OneCare

F3: SELF-REFERRALS AND DIRECT REFERRALS

OneCare members may self-refer for certain covered services within their OneCare health network. Physicians may also directly refer OneCare 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 OneCare health network for the following annual covered services without a referral from their PCP or authorization from OneCare or the member's 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, a pneumococcal vaccine and a tetanus vaccination. OneCare members may not be charged for these vaccines.

OneCare or a health network may require preservice authorization for initial and subsequent procedures, treatments or surgeries.

- **Direct Authorization Referral** — A physician may directly refer a OneCare member for specific covered services by submitting an authorization request directly to the contracted provider. OneCare 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:**

- **Behavioral Health Services** — For more information on how to refer a member for behavioral health services, see **Section C10: Behavioral Health Services**
- **Dental Services** — For more information on how to refer a member for dental services, see **Section D5: Dental Services.**
- **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.**

This section applies to the following CalOptima Health programs:

Medi-Cal

F4: SECOND OPINIONS

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

CalOptima Health 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 for a CalOptima Health member submit the request via the Provider Portal of fax the ARF to the CalOptima Health Utilization Management department.
2. To request a second opinion for a member enrolled in a CalOptima Health network, please contact the member's health network. For Medi-Cal health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information.**
3. Referrals for second opinions should be directed to a provider who is contracted with the member's health network. Referrals to non-contracted medical providers or facilities will be approved only when the requested services are not available within the contracted network.
4. Second medical opinions can only be rendered by a physician qualified to review and treat the medical condition in question.
5. If the provider giving the second medical opinion recommends a particular treatment, diagnostic tests or service that is covered by Medi-Cal and is medically necessary, CalOptima Health or the member's health network will provide or arrange for services.
6. If CalOptima Health or the member's health network denies a request by the member for a second opinion, CalOptima Health or the member's 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
7. CalOptima Health or the member's 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 request such third opinion.

This section applies to the following CalOptima Health programs:

OneCare

F4: SECOND OPINIONS

OneCare members may request a second medical opinion regarding a recommended procedure or service through their PCP. A health network or OneCare 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 of receipt of request
- **Standard preservice** — Within 14 calendar days of receipt of request

OneCare 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 health network. For OneCare health network contact information, see **Section B1: CalOptima Health 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, and if it is medically necessary, the member's OneCare health network will provide or arrange for services.

5. If OneCare or the health network denies a request by the member for a second opinion, OneCare or the member's 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 Health OneCare 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 or the member's 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 Health Policies and Procedures:

GG.1538 Referral for Second Opinion

MA.9015 Standard Integrated Appeals

MA.9004: Expedited Service Appeal

This section applies to the following CalOptima Health programs:

Medi-Cal

F5: TIPS TO EXPEDITE AUTHORIZATION REQUESTS

If submitting an expedited authorization request for a CalOptima Health Direct (COD) or CCN member, the following simple tips will help expedite the authorization request. Please keep the following tips in mind when completing the ARF.

HOW TO EXPEDITE CALOPTIMA HEALTH DIRECT AUTHORIZATION REQUESTS

1. **Use the Provider Portal** – Submitting requests via CalOptima Health's Provider Portal may result in the automatic approval of requests, based on referral rules.

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

3. **Check for the Member's Health Network** — Providers should check to see if the member is enrolled in a CalOptima Health network or in COD.
   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. An authorization from CalOptima Health is not required for Medicare services provided to members in Medicare.
   c. COD covers certain CalOptima Health members, including members who are dually eligible for Medicare and Medi-Cal, in foster care, in long-term care, are Breast and Cervical Cancer Treatment Program members, have end-stage renal disease, have received a transplant, are hemophiliacs, are seniors and persons with disabilities (SPD), are transitioning into a health network and are share of cost members.
   d. Members new to CalOptima Health 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.

4. **Include Critical Information** — Providers should include the following critical information when completing the ARF:
   a. **Member Identification Number** — Due to the large volume of members in the CalOptima Health 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 Health 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 Health will mail Notices of Action letters and/or requests for additional information.

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 Health 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 Health website.
g. **Diagnosis Codes** — ICD-10 diagnosis codes are required. Many of the ICD-10 diagnosis codes are linked to procedure codes, the member's age and their gender. This mapping is programmed into CalOptima Health'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 Health.
i. **Dates of Service and Number of Units** — This information must match the same information provided on the claim submitted.

5. **Do Not Send Duplicates** — All requests are distributed to the prior authorization department. Duplicate requests increase the volume received and slow down the process.

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

7. **Emergency Department (ED) Services** — ED services for COD members DO NOT require prior authorization.

CalOptima Health Policies and Procedures:

GG.1500: Authorization Instructions for CalOptima Health Direct Providers

This section applies to the following CalOptima Health programs:

Medi-Cal

F6: CALOPTIMA HEALTH DIRECT SERVICES REQUIRING AUTHORIZATION

CalOptima Health Direct (COD) 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 DME
- Unlisted, miscellaneous or "by report" codes
- New medical technology (considered investigational or experimental – includes drugs, treatment, procedures, equipment, etc.)
- All admissions to LTC facilities require prior authorization. For more information on admissions to long-term care facilities, see **Section C4: Long-Term Care Service Referrals**.

MEMBERS WITH ASSIGNED PRIMARY CARE PROVIDERS

For 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 requested by either the assigned PCP or contracted specialist, including post-hospital discharge visits.
- All initial requests must originate from the PCP. 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, initial visits must be authorized.
- The specialist may request additional visits once the initial visit request is approved.

MEMBERS WITHOUT ASSIGNED PRIMARY CARE PROVIDERS

For 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 may require authorization.
- Members may self-refer or be referred by other providers to specialists for one visit only.
- Specialist requests may require additional authorization after the initial visit.

CalOptima Health 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 Health may adjust the list of services requiring prior authorization by amending CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health 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 turnaround times.

LIST OF PROCEDURE CODES REQUIRING AUTHORIZATION

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

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

CalOptima Health Policies and Procedures:

GG.1500: Authorization Instructions for CalOptima Health Direct Providers

GG.1508: Authorization and Processing of Referrals

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

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

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

GG.1804: Authorization Process and Criteria for Admission to Continued Stay in, and Discharge from Out-of-State Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)

This section applies to the following CalOptima Health programs:

Medi-Cal

F7: CALOPTIMA HEALTH DIRECT RETROACTIVE AUTHORIZATION REQUESTS

CalOptima Health Direct (COD) will consider retroactive authorization (retro-authorization) requests for services that normally require prior authorization, as long as such request is made within 60 calendar days after the initial date of service, but only under the following conditions:

- When "other coverage" (e.g., Medicare Part A, CCS or other health insurance coverage) **has** denied payment of a claim for services, submission of the request to COD 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 Health could not be established and provision of the required service could not be 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 Health-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 Health auto-assigns and enrolls members to health network choices on the first and16th of the month).

2. CalOptima Health will consider retro-authorization requests that meet one of the following conditions:
   a. Late authorization requests for services to COD members who are eligible on the dates of service may be considered if the request is received by CalOptima Health's Utilization Management department within 60 days of the initial date of service (for inpatient acute services, date of service means date of admission), and:
      i. The member has Other Health Coverage (OHC), or
      ii. The member's medical condition is such that the provider is unable to verify the member's eligibility for Medi-Cal, as applicable, and CalOptima Health eligibility at the time of service.
   b. Late authorization requests for services to COD members who have lost eligibility and regained it may be considered if the request is received by CalOptima Health 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 will 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

CalOptima Health Policies and Procedures:

GG.1500: Authorization Instructions for CalOptima Health Direct Providers

This section applies to the following CalOptima Health programs:

Medi-Cal

F8: WHEELCHAIR AUTHORIZATION AND REPAIR REQUESTS

Medi-Cal covers a wheelchair if:

- There is a mobility limitation affecting the individual's ability to perform activities of daily living (ADLs) or independent activities of daily living (iADLs)
- The mobility limitation cannot be addressed by a cane, crutches or walker
- The beneficiary has expressed a willingness to use the wheelchair

Providers are required to obtain prior authorization from CalOptima Health or one of its health networks for:

- The purchase or rental of a standard or custom wheelchair
- The repair of a standard or custom wheelchair that exceeds $250 or uses any miscellaneous code

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 Health Department and Program Contact Information.**

   If a provider identifies a COD member in need of a standard wheelchair (no customized wheelchairs), the provider should submit the request via CalOptima Health's Provider Portal, located in the Providers section of CalOptima Health's website at www.caloptima.org.

   If a provider is unable to submit the request online, the provider should complete the ARF located on the Providers section of the CalOptima Health website.

2. When completing the ARF for either the health network or COD, the provider must supply the following information:

   a. Member's name, date of birth, phone number, address and CIN
   b. Full name, address, telephone number and signature of the prescribing provider
   c. Date of request and diagnosis related to the need for standard wheelchair
   d. Specific items requested, including HCPCS codes

3. If the request involves a health network member, the provider should submit the ARF to the member's health network. For COD members, the provider should fax the ARF to CalOptima Health's Utilization Management department at **714-246-8579**.

CalOptima Health or the member's health network will approve, modify or deny the request for a standard wheelchair in accordance with CalOptima Health 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 Health Department and Program**

Contact Information.

2. If a provider identifies a COD member in need of a custom wheelchair, the provider should complete both a Customized Wheelchair Evaluation Request (CWER) form and Wheelchair Clinical Questionnaire and attach recent physical exam notes. To obtain copies of these forms, please visit the Providers section of CalOptima Health's website: www.caloptima.org/en/ForProviders/Resources/CommonForms

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 CIN
   b. Full name, address, telephone number and signature of the prescribing provider
   c. Date of request
   d. Specific items 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. For COD members, the provider should fax the CWER, Clinical Questionnaire and most recent physical exam notes to CalOptima Health's Utilization Management department at **714-481-6516**.

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

5. If CalOptima Health or the member's health network approves the request for a customized wheelchair evaluation, CalOptima Health or the health network will arrange for an assessment of the member with a contracted wheelchair provider and a licensed certified medical professional (LCMP) such as a physical therapist (PT) or occupational therapist (OT) or a practitioner who has specific training and experience in complex rehabilitation wheelchair evaluations and justifies the need for the equipment in the beneficiary's home or facility. The PT, OT or practitioner must have no conflict of interest or financial ties with the wheelchair provider/vendor in the evaluation.

6. The wheelchair provider and a LCMP will assess the member and the medical necessity for a customized wheelchair based upon Medi-Cal wheelchair guidelines and CalOptima Health Policy GG. 1531: Criteria and Authorization Process for Wheelchair Rental, Purchase and Repair. The wheelchair provider and a LCMP will submit a letter of recommendation based upon the initial assessment of the member to CalOptima Health or the health network.

7. The letter of recommendation and the provider's original request will be reviewed for approval, modification or denial by the Utilization Management department using its criteria.

If CalOptima Health or the member's health network approves the custom wheelchair, a letter of authorization will be sent to the referring provider and custom wheelchair vendor.

If CalOptima Health or the member's health network modifies or denies a custom wheelchair request, a denial or modification notification of action letter will be sent to the referring provider, the wheelchair provider, as appropriate, and the member.

For more information, see the Custom Wheelchair Request and Approval Process Provider Fact Sheet or call the CalOptima Health 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 within a calendar month 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 or the repair request utilizes miscellaneous or "by report" codes, the provider should contact the member's health network to obtain an authorization request form. For health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information.**

3. If a COD member requires a wheelchair repair costing more than $250 or the repair request utilizes 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 Health website.

4. When completing the form for either the health network or CalOptima Health, the provider must supply the following information:
   a. Member's name, date of birth, phone number, address and CIN
   b. Full name, address, telephone number and signature of the prescribing provider
   c. Date of request and relevant diagnosis
   d. Description of the repair as well as replacement parts.
   e. The ARF must specify the manufacturer, model and serial number of the wheelchair or scooter

5. If the case involves a health network member, the provider should submit the authorization form to the member's health network. For COD members, the provider should fax the Wheelchair Repairs Authorization Request Form to CalOptima Health's Utilization Management Department at **714-481-6516**.

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

CalOptima Health Policies and Procedures:

GG. 1508: Authorization and Processing of Referrals

GG. 1531: Criteria and Authorization Process for Wheelchair Rental, Purchase and Repair

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

F9: NON-EMERGENCY MEDICAL TRANSPORTATION REQUESTS

Non-emergency medical transportation (NEMT) services are a Medi-Cal-covered benefit. If a CalOptima Health member is not able to ride in a taxi, they may qualify for NEMT services under their Medi-Cal benefit. The NEMT benefit is separate and distinct from the OneCare transportation benefit.

Who Qualifies for the Medi-Cal NEMT Benefit? NEMT is covered only when a member's medical and physical condition does not allow the member to travel by bus, passenger car, taxi or another form of public or private conveyance. A member meets the Medi-Cal rules if they:

- 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 NEMT Benefit Work? There are a few other important points to understand about the NEMT benefit:

- NEMT services are subject to prior authorization.
- A physician, physician assistant, nurse practitioner, certified nurse midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, mental health or SUD provider must provide a prescription and physician certification statement (PCS).
- 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 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 NEMT SERVICES FOR A MEMBER

1. Verify the member's eligibility using CalOptima Health's Provider Portal, 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 Health Department and Program Contact Information**.

3. For members enrolled in COD, the provider should complete the Non-Emergency Medical Transportation Authorization Request, which includes the PCS. To obtain a copy of this form, please visit the Providers section of the CalOptima Health website.

4. Please be sure to include the following on the Non-Emergency Medical Transportation 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, physician assistant, nurse practitioner, certified nurse midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, mental health or SUD provider.

6. Fax the Non-Emergency Medical Transportation Authorization Request form to CalOptima Health's Utilization Management department at **714-338-3153**.

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

CalOptima Health Policies and Procedures:

GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical

This section applies to the following CalOptima programs:

Medi-Cal

F10: INCONTINENCE SUPPLY INFORMATION

Medically necessary incontinence supplies are a Medi-Cal-covered benefit for members over 5 years of age. Incontinence supply orders that do not exceed $165 per month are not subject to prior authorization. Incontinence supply orders in excess of $165 per month, and in quantities in excess of the Medi-Cal allowable quantity, require prior authorization.

CalOptima Health contracts with a closed network of incontinence supply vendors for COD 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 their contracted vendors. For health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information.**

1. If a provider intends to order incontinence supplies for a COD member, the provider should review the quantity limits as noted on the Medi-Cal.ca.gov website for the List of Incontinence Medical Supply Billing Codes. If orders exceed the maximum allowable quantities/amounts as referenced above, providers need to submit the ARF with supporting clinical records.

2. Claims received for incontinence supplies delivered to a COD member by a non-contracted vendor will be denied with the following message: The provider and/or vendor of service is NOT a CalOptima Health 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 COD may be provided by any vendor that accepts that primary insurance.

CalOptima Health Policies and Procedures:

GG.1114: Authorization for Disposable Incontinence Supplies

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

G1: AUTHORIZATION PROCESS FOR LONG-TERM CARE

The CalOptima Health Long-Term Support Services (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 CalOptima Health members, regardless of the member's county of residence, health network or program.

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

- Nursing Facility Level A (NF-A)
- Nursing Facility Level B (NF-B)
- Subacute Adult Program
- Subacute Pediatric Program

The following services are processed in the Long-Term Care Program but are reviewed and approved by the Regional Center of Orange County (RCOC):

- 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)

The following services are reviewed and approved in CalOptima Health Utilization Management:

- Skilled Nursing Facility (SNF) Medicare A, Medicare B and Medi-Cal "skilled" services

It is important to note that under CalOptima Health:

- The LTC Authorization Request Form (ARF) replaces the Treatment Authorization Request (TAR) 20-1 form.
- All LTC ARFs for CalOptima Health members are processed by CalOptima Health'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 Health members.

LONG-TERM SERVICES AND SUPPORTS CONTACT INFORMATION

Long-Term Services and Supports Contact Information	**Phone Numbers and Website Addresses**
CalOptima Health Long-Term LTSS information	General: **714-246-8600** or **800-965-8979** Fax Number: **714-246-8843** Website: www.caloptima.org
CalOptima Health LTSS mailing address	CalOptima Health LTSS Authorization Department P.O. Box 11045 Orange, CA 92856

AUTHORIZATION PROCESS QUICK REFERENCE GUIDE

Initial Request

Description	Forms/Resources	Timing Requirements	Reference in Manual
Authorization	LTC ARF Section I–V completed by facility and signed by an M.D. Facilities are not required to submit PASRR 6170 form to CalOptima LTSS As of May 1, 2023, nursing facilities are required to show 1) Confirmation that the PASRR Level I Screening was completed; 2) Whether the Level I Screening result is negative or positive for serious mental illness (SMI) and/or intellectual disability, developmental disability, and or related condition(s) (ID/DD/RC); and 3) the PASRR Case Identification (CID). Minimum Data Set (MDS) if available Medicare/HMO denial Primary insurance denial (Medicare or other insurance denial) Sufficient chart documentation to justify the level of care requested For subacute additional documents required: DHCS 6200-A (Adult) or DHCS 6200 (Pediatric) For ICF, ICF/FF, ICF/DD-H, ICF/DD-N facilities submit only HS 231 form signed by M.D. and RCOC	No later than 21 calendar days after admission or change of payer 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. No 21-Day List requirement for ICF homes/facilities.	LTC ARF Completion Instructions Level of Care Criteria PASRR Completion Instructions

Reauthorization Request

Description	Forms/Resources	Timing Requirements	Reference in Manual
Authorization	LTC ARF Section I completed by facility MDS Level II PASRR Notice of Determination DMH/DDS is not required unless the member has had a significant change in condition Sufficient chart documentation to justify level of care requested For subacute additional documents required: DHCS 6200-A (Adult) or DHCS 6200 (Pediatric) For ICF, ICF/FF, ICF/DD-H, ICF/DD-N facilities submit only HS 231 form signed by M.D. and RCOC	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. Up to 30 days prior to the expiration date of the current active LTC ARF for subacute facilities	LTC ARF Completion Instructions Level of Care Criteria PASRR Completion Instructions

Retroactive Request

Description	Forms/Resources	Timing Requirements	Reference in Manual
Authorization	LTC ARF Sections I-V completed by facility and signed by an M.D. MDS Medicare/HMO denial Primary insurance denial Sufficient chart documentation to justify the level of care requested	Present LTC ARF within 120 calendar days of the State of California's eligibility determination. Must meet specific conditions to qualify for approval (See GG.1809 Retroactive Authorization Request for Long-Term Care Facility). The facility is responsible to check eligibility two times a month.	LTC ARF Completion Instructions Level of Care Criteria PASRR Completion Instructions

Authorization Request Treatment in Place – CalOptima LTSS has cancelled/discontinued Treatment in Place program for CalOptima members.

Description	Forms/Resources	Timing Requirements	Reference in Manual
Does not require authorization (but does require notification). Treatment in place requires	OneCare/CCN members only Use LTC Treatment in Place Notification Form.	Nursing Facility (NF) notifies LTSS within 24 hours of start date of services, or the next	LTC Treatment in Place Notification Form

Description	Forms/Resources	Timing Requirements	Reference in Manual
authorization from LTSS case manager		business day by telephone or facsimile. Does not require prior authorization.	Completion Instructions

Bed Hold/LOA-Request

Description	Forms/Resources	Timing Requirements	Reference in Manual
Authorization not required for members who are in long-term care with an authorization already in place. The nursing facility can submit a claim with the correct bed hold codes for payment. All other bed hold requests must be submitted with Authorization Request Form (ARF) and substantiating documentation.	LTC ARF Section I completed by facility. M.D. order with dates of service, 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.	Must be 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, when the member changes to other payer or if the member does not return before day 8.	LTC ARF Completion Instructions

Discharge Notification

Description	Forms/Resources	Timing Requirements	Reference in Manual
Discharge Disposition Form We accept the Discharge Disposition Form for all discharges from an LTC nursing facility. When a member is discharged/transferred to an acute hospital and stays more than the required bed hold days, the nursing facility is required to submit Discharge Disposition Form.	Discharge Disposition Form is required for all community discharges and must have community primary care provider (PCP) name and the member's address and phone number. Post-discharge plan (when member discharged to community) Discharge Notification Form (MC 171) applicable for NF and SNF only completed by the nursing facility staff and sent to appropriate agency.	Within one business day of discharge.	LTC ARF Completion Instructions Discharge Notification

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

G2: INITIAL AUTHORIZATION: SKILLED NURSING FACILITIES (SNF), NURSING FACILITY LEVEL A (NF-A) AND LEVEL B (NF-B)

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

- The CalOptima Health member is a new admission to the facility.
- The CalOptima Health member has exhausted Medicare benefits.
- There is a Medicare, facility or other insurance denial.
- The member has had a readmission from general acute care hospital (did not return on day number eight).
- The member returns from an approved leave of absence beyond the approved time period allowed.
- The resident has become a CalOptima Health 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 Health). Please review the section of this manual pertaining to member eligibility for more specific eligibility guidelines.
- When the CalOptima Health plan is no longer responsible for a short stay.

Process to Obtain a CalOptima Health LTC Authorization

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

LTC Authorization Request Form Process:

Currently NCMs do not perform on-site visits.

For Nursing Facility

Complete sections I, II, III, IV and V of the LTC ARF, including signed physician order for initial LTC admission **only** if LTC ARF is not signed by a physician, and documentation to support the level of care requested, and fax or email to LTSS department. Fax-in facilities are not required to submit monthly census report and 21 Day List to LTSS department.

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

- Facilities are not required to submit PASRR 6170 form to CalOptima LTSS
- As of May 1, 2023, nursing facilities are required to show 1) Confirmation that the PASRR Level I Screening was completed; 2) Whether the Level I Screening result is negative or positive for SMI and/or ID/DD/RC; and 3) the PASRR Case Identification (CID).
- Medicare, facility or other insurance denial, if appropriate
- Minimum Data Set (MDS) if available and sufficient chart documentation to support the medical necessity for the level of care requested

- 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 Health 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 meet level-of-care criteria, a 15% 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 of the on-site visit.
- Authorization and payment are based upon the level of care determination.

Final LTC-ARF Review/Adjudication Process:

CalOptima Health LTC-NCM will review the initial LTC ARF and make determination to approve, deny or modify per DHCS standard clinical criteria for long-term care services and CalOptima Health LTSS policy.

If the initial LTC ARF is approved, CalOptima Health LTSS department will fax a copy of the LTC Authorization Summary Letter to the facility and LTC ARF reference number will be given at that time.

LTC Initial Authorizations Timelines for NF A/B Nursing Facility:

- For members, **with or without LTC aid codes** residing at an NF-B level of care, the initial authorization approvals should be for two months or up to two years based on the clinical judgement of the LTC NCM.
- For members, **with or without LTC aid codes** residing at an NF-A level of care, the initial authorization should be for two months or up to one year based on the clinical judgement of the LTC NCM.

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 Health Policies and Procedures:

CMC.1818 Treatment in Place for CalOptima Community Care Network (CCN) Members residing in Long-Term Care Facilities

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 section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

G3: REAUTHORIZATION — REGULAR: SKILLED NURSING FACILITIES, NURSING FACILITY LEVEL A (NF-A) AND LEVEL B (NF-B)

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.

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

Process for obtaining a reauthorization

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

- **Authorization:** Complete sections I, III and IV of the LTC ARF, including a physician signature (may provide a signed "admission to LTC" order in lieu of M.D. signing the ARF) and documentation to support the level of care requested, and present to the CalOptima Health on-site nurse.

- **Final Adjudication:** After review, the LTC Nurse Case Manager will adjudicate the LTC ARF and clinical supporting documents submitted. If the LTC ARF is approved, CalOptima Health will fax a copy of the approval letter to the facility and an LTC ARF reference number will be given at that time.

- **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 Health 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 section applies to the following CalOptima Health programs:

Medi-Cal

G4: INITIAL AUTHORIZATION: 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)

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).

- 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.
- The Regional Center shall determine the facility placement and level of care for a developmentally disabled member.
- 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.
- CalOptima Health Long-Term Services and Supports (LTSS) 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.
- 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 Health LTSS department shall document the authorization as requested in the medical management system and provide an authorization number to the admitting facility.
- CalOptima Health'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 the signed HS 231 form with reauthorization information to CalOptima Health.
- Upon notification by the facility of a member's discharge, CalOptima Health LTSS shall close the active LTC authorization effective the day of discharge. The facility shall notify CalOptima Health within three business days of a member's discharge by submitting the Discharge Disposition Form.
- CalOptima Health shall ensure continuity of care for members residing in an ICF/DD, ICF/DD-H, ICF/DD-N in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima Health.
- 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) A non-Medi-Cal provider renders the medical service
    b) The medical service does not meet medical necessity and results in a denial. CalOptima Health Utilization Management will issue the Notice of Action (NOA) to the ICF facility to include

information on a member's appeal rights, in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

Process for obtaining a CalOptima Health LTC Authorization:

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

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

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

- **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).

CalOptima Health 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

This section applies to the following CalOptima Health 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 Health eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

- **Authorization:** Fax the following documents to CalOptima Health Long-Term Services and Supports (LTSS) Authorization:
    a. LTC ARF with section I, II, IV and V completed and signed by the physician
    b. The HS 231 form signed by the physician and 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, CalOptima Health LTSS shall request the facility resubmit completed required documentation.

- **Final Adjudication:** The CalOptima Health LTSS staff will review the submitted LTC ARF. CalOptima Health'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.

- **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 Health 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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

G6: INITIAL AUTHORIZATION — SUBACUTE/ADULT AND PEDIATRIC

CIRCUMSTANCES REQUIRING A CALOPTIMA HEALTH LTC AUTHORIZATION REQUEST FORM (ARF):

- The CalOptima Health member is a new admission to the nursing facility (NF).
- The CalOptima Health member has exhausted Medicare benefits.
- There is a Medicare, facility or other insurance denial.
- The member has had a readmission from general acute care hospital (did not return on day number eight).
- The member returns from an approved leave of absence beyond the approved time period allowed.
- The resident has become a CalOptima Health 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 Health). Please review the section of this manual pertaining to member eligibility for more specific eligibility guidelines.

PROCESS FOR OBTAINING A CALOPTIMA HEALTH LTC AUTHORIZATION

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

- **Authorization:** Complete section I, II, III, IV and V of the LTC ARF, including physician signature (may provide a signed M.D. order for admission in lieu of M.D. signature on ARF) and documentation to support the level of care requested, and present to CalOptima Health.
- **The CalOptima Health LTC ARF** must be presented with the following documentation for adjudication:

    a. Facilities are not required to submit PASRR 6170 form to CalOptima LTSS

    b. As of May 1, 2023, nursing facilities are required to show 1) Confirmation that the PASRR Level I Screening was completed; 2) Whether the Level I Screening result is negative or positive for SMI and/or ID/DD/RC; and 3) the PASRR Case Identification (CID)

    c. Medicare, facility or other insurance denial, if appropriate

    d. Minimum Data Set (MDS) if available, and sufficient chart documentation to support the medical necessity for the level of care requested

e. 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 Health 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% payment reduction will be assessed from day one until the member's name and admission date were placed on the 21 Day List and faxed to CalOptima Health LTC Program.

- **Final Adjudication:** After review, the assigned LTC nurse case manager will adjudicate the LTC ARF and supporting documents submitted. If the ARF is approved, CalOptima Health will fax a copy of the approval letter to the facility and LTC ARF reference number will be given at that time. If the services are modified or denied, the NF will receive a Notice of Denial (NOD). A NOD will also be sent to the member/responsible party in the member's preferred language.

- **Authorization Periods**: Authorizations may be granted for up to six-month time periods based on the nurse case manager's clinical judgement.

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

GG.1807 Authorization Review Process, Long-Term Care

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

G7: REAUTHORIZATION — SUBACUTE/ADULT AND PEDIATRIC

TIMELINESS REQUIREMENTS FOR REAUTHORIZATION REQUESTS:

- 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.

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

PROCESS FOR OBTAINING A REAUTHORIZATION:

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

- **Authorization:** Complete and present the following documents to the CalOptima Health on-site nurse prior to the expiration of the current authorization:
    a. Sections I, III, IV of the LTC ARF, including a physician signature and/or signed MD order for admission to the facility
    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% payment reduction will be assessed from day one until the LTC ARF is presented.

- **Final Adjudication:** After review, the assigned nurse case manager will adjudicate the LTC ARF with supporting documents submitted. If the LTC ARF is approved, CalOptima Health will fax a copy of the approval letter to the facility, and an LTC ARF reference number will be given at that time.

- **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 Health 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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

G8: RETROACTIVE ELIGIBILITY: AUTHORIZATION AND PROCESS GUIDELINES

DETERMINING RETROACTIVE ELIGIBILITY:

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

- (LTC ARFs are due within 120 calendar days of the State of California's eligibility determination regardless of when the provider identifies eligibility.

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

Note: Always verify CalOptima Health 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 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, regardless of when the facility identifies eligibility. Authorization requests that are submitted after the 120-calendar-day requirement shall be subject to a 15% payment reduction.

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

Authorization and payment are based upon the level of care determination.

Note: For easier coordination of care, out-of-county facilities are encouraged to work with the member or the 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 Health 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.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

G9: BED HOLD AND LEAVE OF ABSENCE: AUTHORIZATION REQUESTS

GENERAL RULES FOR BED HOLD:

- There must be a physician order for transfer to general acute care hospital and a bed hold order written at the same time of the member's transfer to general acute care hospital.
- Bed hold requests are payable when the member meets eligibility for Medi-Cal with CalOptima Health and the member's stay is being covered by Medicare or Medicare HMO, and the member is admitted into a general acute care hospital.
- If the facility is aware that the member requires more than seven days of general acute care hospitalization, the facility is not required to hold the bed and shall not bill CalOptima Health for any remaining bed hold days.
- Bed hold payment terminates on the member's day of death.
- The facility shall be required to hold the bed vacant when requested by the member or the member's authorized representative, unless notified that the member requires more than seven days of general acute hospital care.
- 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.
- Facilities receiving payment for contracted beds are not eligible for bed hold reimbursement for those beds.
- 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.
- 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.

Bed Hold/ LOA-Request

Description	Forms/Resources	Timing Requirements	Reference in Manual
Authorization is not required for members who are in long-term care with an authorization already in place. The nursing facility can submit a claim with the correct bed hold codes for payment. All other bed hold requests must be submitted with an Authorization Request Form (ARF) and substantiating documentation.	LTC ARF Section I completed by facility. MD order with dates of service, 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.	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 eight.	LTC ARF Completion Instructions

GENERAL RULES FOR LEAVE OF ABSENCE:

- Patient plans of care for all CalOptima Health 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.

- 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.

- 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).

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

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

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

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

- 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.

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. BEING AWOL BEYOND MIDNIGHT OF THE NIGHT OF LEAVING CONSTITUTES A DISCHARGE AND REQUIRES A NEW AUTHORIZATION PROCESS TO OBTAIN A CALOPTIMA HEALTH LTC AUTHORIZATION FOR BED HOLD.

CalOptima Health member without approved LTC authorization services already in place during skilled short stay:

- Bed Hold (BH) LTC ARF is required for CalOptima Health members admitted for skilled short stay services without LTC authorization already in place before acute hospital transfer/admission. LTC nursing facility will be required to submit bed hold authorization request (ARF) to CalOptima Health LTSS department.

- CalOptima Health members admitted for skilled short stay services require BH authorization requests when skilled services are being authorize by Medicare, CalOptima Health UM department (CCR), health network providers and member does not have approved LTC authorization already in place.

Member with approved LTC authorization already in place before acute hospital transfer/admission

- LTC nursing facility is not required to submit BH LTC ARF for CalOptima Health members with approved LTC authorization services.

- LTC nursing facility may submit BH payment request to CalOptima Health Claims with appropriate BH accommodation codes for LTC level of care.

LTC BH Authorization Process

LTC nursing facility will present LTC BH ARF and supporting documents to the on-site nurse during regular scheduled on-site visit, or fax LTC BH ARF and supporting documents to CalOptima Health LTSS 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 the eighth day:

a. The completed LTC ARF with an X placed in the box marked Bed Hold/LOA. Enter 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 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% payment reduction does not apply. **There is no payment for a late bed hold request.**

- **Final Adjudication:** After review, the on-site nurse will adjudicate the LTC ARF during the regularly scheduled facility visit. If approved, CalOptima Health 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 the 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 MEMBERS

- A nursing facility shall hold a bed vacant when requested by a OneCare 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.
- A bed hold for a OneCare member admitted to a general acute care hospital is limited to seven days per hospitalization.
    a. The day of departure from the nursing facility shall be counted as day one of bed hold.
    b. 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 a 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.

- The nursing facility will hold the bed vacant during the bed hold period.
- 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 for any remaining bed hold days.
- 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.
- OneCare 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).
- OneCare shall not pay for bed hold days when a member is discharged from a facility that is receiving payment for a bed hold within 24 hours after the member's return from a general acute care hospital.
- If a member dies while hospitalized, the nursing facility shall terminate the bed hold and OneCare shall not pay the facility for the bed hold for the day of death.
- The nursing facility shall present the on-site nurse or send the authorization request for bed hold reimbursement to OneCare Long-Term Services and Supports (LTSS) within 21 calendar days after the end of the bed hold.

- If OneCare LTSS staff receives an authorization request more than 21 calendar days after the end of the bed hold, OneCare shall consider the authorization late and shall not reimburse the nursing facility for the bed hold. The 15% payment reduction does not apply to bed hold requests.
- 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.
- OneCare 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.
- 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 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).
- 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 Health 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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

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

LTC ARF DEFERRAL PROCESS: ORANGE COUNTY FACILITY AND OUT-OF-COUNTY NURSING FACILITIES

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

- When the NCM is not in receipt of a complete LTC ARF, and supporting documents as listed in Policy 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), the NCM will contact the nursing facility to request missing documents and upload LTC ARF and supporting documents into Guiding Care system. For activities with incomplete documents, the NCM will have up to 14 business days to obtain the documents from the nursing facility and make a decision.

- In some special cases, if requested by a CalOptima Health member, LTC nursing or a facility/provider, or if LTC NCM justifies that additional information being requested is in the best interest of member's care; the LTC NCM may extend the LTC ARF for an additional 14 days, giving the provider and/or member a maximum of 28 calendar days from the date of LTC ARF presentation/notification to provide the required documents. A delay letter will be created and sent to the member and provider specifying the medical records needed and the date the documents are due. For example, if LTC facility is waiting for specialist consults, notes or the additional examinations that will help LTC NCM determine level of care.

- LTC ARF deferred by the LTC NCM shall be reviewed within 14 calendar days from the date of the extension/deferral. LTC NCM shall reschedule an on-site visit or can review the deferred LTC ARF as a faxed-in request within the 14 calendar days of the Delay Letter and before the 28th day.

- The NCM will send activity to CalOptima Health Medical Director for all **medical necessity reviews** when unable to make a determination due to level-of-care criteria not being met, or there is insufficient documentation of medical necessity. CalOptima Health Medical Director will review LTC ARF and make final determination to **approve, modify or deny.** The NCM will follow the LTC approval, denial or modification notification process for CalOptima Health members and providers.

- CalOptima Health shall send a Notice of Action (NOA) letter to the provider and CalOptima Health member. The member denial letter will be sent in the member's preferred language.

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

CalOptima Health 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.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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

G11: DISCHARGE NOTIFICATION

DISCHARGE DISPOSITION FORM REQUIREMENT:

- Long-term care (LTC) facility shall notify CalOptima Health's Long-Term Services & Supports (LTSS) department utilizing the Disposition Form within 24 hours of member's discharge from the facility.
- LTC facility shall assist CalOptima Health member choose a community primary care provider (PCP) when CalOptima Health member is being discharge to the community setting.

DISCHARGE NOTIFICATION IS REQUIRED WHEN:

- CalOptima Health member does not return from an approved bed hold/leave of absence period, i.e., does not return on the eighth day after a general acute care hospital admission
- CalOptima Health member returns to the facility during the bed hold period, but the stay is covered by another payer, i.e., Medicare/HMO
- CalOptima Health member expires during an approved bed hold
- There is a change in payer source without an actual discharge from the facility
- CalOptima Health member returns before the eighth day, but readmitted under skilled short stay services, even if CalOptima Health is the payer source (Medicare, HMO, SRG, CalOptima Health Community Network)
- CalOptima Health member is discharged to other care facilities during an approved bed hold (community setting, board and care, assisted living, hospice care and Congregate Living Health Facility (CLHF) homes)

NOTIFICATION PROCESS:

- For bed hold discharges, fax a copy of the previously authorized LTC Authorization Request Form (ARF) for bed hold with start and end date of the bed hold and Discharge Disposition form 24 hours after member's discharge.
- 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.
- 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 Health member residing in their facilities and send form (MC 171) to appropriate agency.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

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

(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(l): **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:

(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 Health 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).

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

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 weighs 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 Health 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):

a. Conditions outlined in c, d, e and f above, but of lesser severity, intensity or degree than alluded to in Section 1 above
b. Occasional incontinence — on bowel and bladder retraining programs
c. 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
d. 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.
    a. Conditions outlined in a and b of 1 above, but of lesser severity, intensity or degree than alluded to in those sections
    b. Cases in which the documented history and/or diagnosis gives clear indication of progressive incapacitation
    c. Dependence for activities of daily living — dependent upon degree
    d. Sensory impairment
    e. Generalized weakness or feebleness
    f. 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.

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:
    1. A tracheostomy with continuous mechanical ventilation for at least 50 percent of the day
    2. Tracheostomy care with suctioning and room air mist or oxygen as needed and one of the six treatment procedures listed in Section F
    3. 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

This section applies to the following CalOptima Health programs:

OneCare

G14: LONG-TERN 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 Health's LTSS department shall process all requests for admission to, continued stay in, or discharge from a NF-A and/or NF-B pursuant to the DHCS standard clinical criteria for level of care.

OneCare shall approve authorization requests to NFs if they are licensed by the California Department of Public Health (CDPH), meet acceptable quality standards, and the NFs and CalOptima Health agree to Medi-Cal rates in accordance with CalOptima Health 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 NF shall submit a completed LTC ARF (Sections I through V), MDS, Provider Utilization Committee Determination (Medicare or other insurance denial) as appropriate, 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 Health 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 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 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 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 Health 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.
        ii. OneCare 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 Health 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 Health OneCare may extend a deferral for 14 days only via an Extension Request form. Should CalOptima Health LTSS department be unable to approve the LTC ARF due to insufficient documentation of medical necessity, CalOptima Health LTSS department shall submit the LTC ARF and accompanying documentation to the OneCare medical director or authorized physician designee for review and determination.

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

vi. If the OneCare medical director or designee denies the LTC ARF, CalOptima Health LTSS department shall notify the facility, member or the member's authorized representative, and the attending physician in accordance with CalOptima Health 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 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 approves the LTC ARF, OneCare 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 Health 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 Health 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 shall close the active LTC ARF, effective the day of discharge.

CalOptima Health Policies and Procedures:

GG.1508: Authorization and Processing of Referrals

GG.1800: ARF Process & 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

GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial, Modification, or Recommendation

EE.1135: Long-Term Care Facility Contracting

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H1: DETERMINING WHICH CLAIMS PROCESS APPLIES

When a provider files a claim for payment, determining which claims processing guidelines apply depends on whether the member is in a health network or CalOptima Health Direct, as well as the type of health network. CalOptima Health Direct and each CalOptima Health-contracted network have their own claims processing function.

As a result, it is essential that a provider identifies 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

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

- **HMO or PHC Health Network Members** — Providers should file claims with the member's health network and follow its claims processing guidelines.
- **SRG Health Network Members** — Providers should file professional claims with the SRG and follow its claims processing guidelines. Providers should file facility claims and most ancillary claims with CalOptima Health and follow CalOptima Health's claims processing guidelines for those claims. OneCare health networks will utilize CalOptima Health's OneCare claims addresses for facility claims.
- **CalOptima Health Direct/CalOptima Health Community Network Members** — Providers should file all claims with the CalOptima Health Claims department and follow CalOptima Health's claims processing guidelines.

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

Health Network	Professional Claims	Facility Claims
AltaMed Medi-Cal Group (SRG) **Medi-Cal, OneCare**	AltaMed Health Services P.O. Box 7280 Los Angeles, CA 90022-7280	**Electronic Claims:** Emdeon or Office Ally (See **Section H3** of this manual for details) **Hard Copy Claims (only applicable for Medi-Cal facility claims):** CalOptima Health Direct Claims P.O. Box 11065 Orange, CA 92856 For OneCare program, use CalOptima Health OneCare claims address. (See **Section H4** of this manual for details)

Health Network	Professional Claims	Facility Claims
AMVI Care Health Network (PHC) **Medi-Cal**	AMVI Care Health Network P.O. Box 11466 Santa Ana, CA 92711	AMVI Care Health Network P.O. Box 11466 Santa Ana, CA 92711
CalOptima Health Direct/CalOptima Health Community Network	**Electronic Claims:** Emdeon or Office Ally (See **Section H3** of this manual for details) **Hard Copy Claims:** CalOptima Health Direct Claims P.O. Box 11037 Orange, CA 92856 (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:** CalOptima Health Direct Claims P.O. Box 11037 Orange, CA 92856 (See **Section H4** of this manual for details)
CHOC Health Alliance (PHC) **Medi-Cal**	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 **Medi-Cal, OneCare**	Family Choice Health Network P.O. Box 260830 Encino, CA 91426	Medi-Cal Claims Family Choice Health Network P.O. Box 260830 Encino, CA 91426 OneCare Claims CalOptima Health OneCare Claims P.O. Box 11065 Orange, CA 92856
HPN-Regal Medical Group (HMO) **Medi-Cal, OneCare**	Regal Medical Group P.O. Box 371330 Reseda, CA 91337	Regal Medical Group P.O. Box 371330 Reseda, CA 91337
Noble Mid-Orange County (SRG) **Medi-Cal, OneCare**	NobleMid-OC P.O. Box 6300 Cypress, CA 90630-0063 (For submission via Office Ally, use payor ID: HSM01)	**Electronic Claims:** Emdeon or Office Ally (See **Section H3** of this manual for details) **Hard Copy Claims (Medi-Cal only):** CalOptima Health Direct Claims P.O. Box 11065 Orange, CA 92856 For OneCare program, use CalOptima Health OneCare claims address. (See **Section H4** of this manual for details)

Health Network	Professional Claims	Facility Claims
Optum (HMO) **Medi-Cal, OneCare**	Optum Claims 11 Technology Drive Irvine, CA 92618	Optum Claims 11 Technology Drive Irvine, CA 92618
Prospect Medical Group (HMO) **Medi-Cal, OneCare**	Prospect Medical 600 Parkway West Orange, CA 92868	Prospect Medical 600 Parkway West Orange, CA 92868
United Care Medical Group (SRG) **Medi-Cal, OneCare**	United Care Medical Group P.O. Box 2859 Garden Grove, CA 92842	**Electronic Claims:** Emdeon or Office Ally (See **Section H3** of this manual for details) **Hard Copy Claims:** CalOptima Health Direct Claims P.O. Box 11065 Orange, CA 92856 For OneCare program, use CalOptima Health OneCare claims address. (See **Section H4** of this manual for details)

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H2: CLAIMS PROCESSING OVERVIEW: CALOPTIMA HEALTH DIRECT AND SHARED RISK CLAIMS

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

- CalOptima Health Direct fee-for-service claims (professional and facility)
- CalOptima Health 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 Health recognizes that a key component of quality health care is timely and efficient medical claims processing. CalOptima Health 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 Health's claims processing steps.

PROCESSING STEPS

1. **Edits/Audits** — All claims entering the CalOptima Health 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
    h. Verify line(s) or claim level for accurate pricing/payment

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.

4. **Claims Filing Time Frames** — A provider shall submit a claim for covered services provided to a COHD-A member, CHCN member or a member enrolled in a Shared Risk Group within 365 calendar days after the month of the date of service. Refer to policy FF.2001, Section E Claim Filing Deadlines

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

CalOptima Health Policies and Procedures:

FF.2001: Claims Processing for Covered Services Rendered to COHD or SRG Members

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H2: CLAIMS PROCESSING OVERVIEW: ONECARE (HMO D-SNP), A MEDICARE MEDI-CAL PLAN

The OneCare department is responsible for processing claims for facility services rendered to OneCare. This section provides an overview of how the OneCare Claims department processes facility claims. OneCare's health networks are responsible for payment of professional claims for OneCare members.

PROCESSING STEPS

OneCare recognizes that a key component of quality health care is timely and efficient medical claims processing. OneCare processes facility claims according to Medicare guidelines and also uses industry standard guidelines to promote timely and efficient processing of both paper and electronic claims.

- **Claims Filing Time Frames** — OneCare follows The Centers for Medicare & Medicaid Services (CMS) guidelines for timely filing of claims. Providers should file claims within the applicable time frames.
  a. Providers have one year from the date of service to submit a claim for covered services rendered on or after January 1, 2010.
  b. Claims not submitted within the appropriate time frame will be denied by OneCare.

- **Edits/Audits** — All claims entering the OneCare system are processed 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
  h. Verify line(s) or claim level for accurate pricing/ payment

- **Claims Pending Review** — Claims that fail an edit or audit check are placed in a "pended" status for review by a claims examiner. Claims placed in a pended status are reviewed as follows:
  a. A claims examiner reviews a scanned image of the pended claim as well as any attachments (if transmitted in hard copy). The claims examiner identifies the reason for the claim's pended status.
  b. Claims requiring medical judgment are reviewed by a physician or other qualified medical professional in accordance with the provisions of CMS and policies established by the Department of Health Care Services (DHCS).

- **Reimbursement** — Claims that successfully clear the processing cycle are adjudicated based on reimbursement guidelines contained in the provider's contract with OneCare or on Medicare reimbursement guidelines for non-contracted providers. If a claim is paid by OneCare, the Remittance Advice indicates the payment status. If a claim is denied or contested by OneCare, the Remittance Advice contains the reason for contesting or denying the claim.

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to **non-contract** MIPS eligible clinicians. A marker percentage indicates that the MIPS Adjustment Percentage is positive ("P") or negative ("N").
Evaluation is conducted on an annual basis and the maximum MIPS adjustment percentages increase year over year from 2019 to 2022 for MIPS eligible clinicians:

- The maximum positive and negative MIPS adjustments payment for each year is: 2019, +/-4%, 2020, +/-5%, 2021, +/-7% and 2022, +/-9%.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H3: ELECTRONIC CLAIMS SUBMISSION: CALOPTIMA HEALTH DIRECT, SHARED RISK AND ONECARE (HMO D-SNP) CLAIMS

CalOptima Health accepts claims in both electronic and hard copy formats. This section provides information about electronic claims submission, including Electronic Data Interchange (EDI) claims, CMS 1500 or UB04 forms, and Long-Term Care (25-1) electronic billing. For information regarding hard copy billing, see **H4: Hard Copy Claims Submission — CalOptima Health Direct, Shared-Risk and OneCare (HMO D-SNP) Claims.**

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

ADVANTAGES OF ELECTRONIC SUBMISSION

CalOptima Health strongly encourages electronic claims submission for the following benefits:

- 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 HEALTH

- EDI claims

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

Change Healthcare
866-817-3813
https://www.changehealthcare.com

Office Ally
866-575-4120
www.officeally.com

- **CalOptima Health Payer Identification Numbers**
  Use the following CalOptima Health payer identification (ID) numbers when sending claims electronically to CalOptima Health. (Note that Emdeon and Office Ally have their own payer identification number and each vendor processes different types of claims):
  a. **Change Healthcare: 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) and facility (UB) claims.
     - **Payer ID "COLTC" —** For Submission of long-term care (25-1 Form Electronic Billing)
  c. **Pediatric Preventive Services** —. Effective July 1, 2018, the Childhood Health and Disability Prevention program transitioned claims submissions from PM160 to national standards CMS 1500 or UB04 forms. 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 Health contracts with Change Healthcare and Office Ally 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 either Change or Office Ally at the phone numbers referenced above.

REMINDER ABOUT TIMELY FILING

CalOptima Health 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 in a timely manner (e.g., retro eligibility issue).

CHECKING THE STATUS OF A CLAIM ONLINE

Providers can view claim status, check eligibility, and submit and check referrals and authorization on CalOptima Health's Provider Portal on CalOptima Health's website at www.caloptima.org.

New users need to register prior to using the Provider Portal. Registration link and instructions, user guides and training videos are on CalOptima Health's website at http://www.caloptima.org/en/ForProviders/ProviderPortal. For more information on verifying a member's eligibility, see **Section E1: Verifying Member Eligibility. This section might need to be reviewed if it references the old CalOptima Health Link**

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H4: HARD COPY CLAIMS SUBMISSION: CALOPTIMA HEALTH DIRECT, SHARED RISK, ONECARE (HMO D-SNP), A MEDICARE MEDI-CAL PLAN

CalOptima Health 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 Health Direct, Shared-Risk, and OneCare (HMO D-SNP)**

Note: The CalOptima Health Claims department is responsible for processing CalOptima Health 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 Health is financially responsible.

GUIDELINES FOR HARD COPY CLAIMS SUBMITTED TO CALOPTIMA HEALTH

This section explains the basic billing guidelines required for CalOptima Health 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 Health 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 Health, 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

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 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 HEALTH

1. **Timely Filing**
   CalOptima Health 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 Health, 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 HEALTH

To submit a claim in hard copy format for CalOptima Health Direct, or Shared-Risk Medi-Cal members, submit claims to CalOptima Health using the address below:

Original Claims
CalOptima Health Claims Department
P.O. Box 11037
Orange, CA 92856

CHECKING THE STATUS OF A CLAIM ONLINE

Providers can view claims status and/or check status on the CalOptima Health Link located on CalOptima Health's website at www.caloptima.org/. New users will need to register with CalOptima Health Link. Follow the instructions for checking the status of a claim or a check.

For more information regarding CalOptima Health Link, see **Section E1: Verifying Member Eligibility**.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to 12 p.m. and 12:30 to 4 p.m.

CalOptima Health Policies and Procedures:

FF. 2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct Members or Members Enrolled in a Shared Risk Group

MA.3101: Claims Processing

This section applies to the following CalOptima Health Direct programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H5: SUBMITTING CROSSOVER CLAIMS

A crossover claim is one where 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 Health Direct 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 Health Direct 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 Health Direct.

Guidelines for hard copy claims submitted to CalOptima Health Direct required complete CMS 1500, UB04 or 25-1 claims forms with Explanation of Medicare Benefits (EOMB). Refer to Policy FF.2003 for additional information.

HOW TO FILE A CROSSOVER CLAIM

To submit a crossover claim for a Medi-Medi member, please use the address below:

Type of Claim	Address for Submission
Medi-Medi Crossover — All Claim Types	**Effective June 1, 2014, providers must submit all crossover claims to:** CalOptima Health Direct Crossover Claims Unit P.O. Box 11070 Orange, CA 92856

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H6: RETURNED CLAIM NOTIFICATION LETTER — CALOPTIMA HEALTH DIRECT

A returned claim notification letter indicates that CalOptima Health has recently received your claim(s) for services rendered to a CalOptima Health member and the corrections 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, UB04 or 25-1 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 Health system.

WHAT TO DO IF YOU RECEIVE A RETURNED CLAIMS NOTIFICATION LETTER

- 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.
- If you receive a rejection letter, correct the claim form after reviewing all indicated problems and send the original hard copy to:

  CalOptima Health Direct
  P.O. Box 11037
  Orange, CA 92856

CalOptima Health Direct Returned Notification Letter/Problem Resolution

Provider Problems	How to Avoid
Provider is not actively registered in our system as a CalOptima Health Direct provider.	Contact our Provider Relations department at **714-246-8600**
Provider is using a different NPI # (other than the NPI # registered with CalOptima Health).	Contact our Provider Relations department at **714-246-8600**
Provider ID # and Federal Tax ID # are not affiliated.	Contact our Provider Relations department at **714-246-8600**

Member Problems	How to Avoid
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 Health Link located on CalOptima Health's website at www.caloptima.org • CalOptima Health'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

Incomplete/Misc. Claim Form	How to Avoid
Missing required information	Please correct and submit as an original CMS 1500, UB04 or 25-1 form. **NOTE**: To avoid a delay in payment of your claims, complete all required information.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H7: OTHER HEALTH COVERAGE

When a member has other health coverage, CalOptima Health 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 Health. The OHC carrier may reimburse at a higher rate than CalOptima Health. If a provider receives a partial payment from the OHC carrier, CalOptima Health 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.

Providers enrolled in Medi-Cal Fee-for-Service (FFS) or as a Medicare provider do not need to be contracted with CalOptima Health in order to see and bill for routine services for a patient who is dual-eligible or has OHC and is enrolled in CalOptima Health. For providers who are enrolled in Medi-Cal FFS, but do not contract with CalOptima Health, they may still see a CalOptima Health member for a limited duration under continuity of care requirements by leveraging a letter of agreement (LOA) or similar mechanism when the service would typically require a prior authorization.

To bill Medi-Cal after billing the OHC, a provider must present acceptable forms of proof to CalOptima Health that all sources of payment have been exhausted, which may include a denial letter from the OHC for the service or an explanation of benefits indicating that the service is not covered by the OHC.

CalOptima Health's reimbursement is the difference between the CalOptima Health allowable amount and the OHC carrier payment.

IMPORTANT REMINDERS REGARDING OHC

1. **Exclusions** — The following are not considered other health coverage:
    a. CalOptima Health managed care*
    b. Automobile insurance
    c. Life insurance

***Note:** CalOptima Health managed care is not other health coverage. Providers should refer recipients enrolled in CalOptima Health managed care plans to the plan for treatment unless the provider is authorized to treat under the plan guidelines.

2. **Reporting OHC** — State law requires CalOptima Health providers to notify the Department of Health Care Services (DHCS) if they believe a recipient may be entitled to OHC.

    Please call DHCS at 800-952-5294 between 8 a.m. and 5 p.m. to report possible OHC, 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 OHC insurance plan.

3. **Nondiscrimination of CalOptima Health beneficiaries**
   Under state law, when a provider obtains proof of eligibility, the provider must accept the CalOptima Health recipient and be bound by the rules and regulations of the CalOptima Health 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 Health is not liable for OHC-covered services if the recipient elects to seek treatment from a provider not authorized by the OHC.

4. **OHC cost sharing**
   Providers are prohibited from billing CalOptima Health recipients, or persons acting on their behalf, for any amounts other than the CalOptima Health copayment or share of cost. Therefore, if the recipient's OHC requires a copayment, coinsurance, deductible or other cost sharing, the provider cannot bill the recipient. If the provider bills the OHC and the OHC denies or reduces payment because of its cost-sharing requirements, the provider may then bill CalOptima Health. CalOptima Health will adjudicate the claim, deducting any OHC payment amounts.

5. **When to bill OHC**
   When requesting eligibility verification for a recipient with OHC, the CalOptima Health 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 Health.

OTHER HEALTH COVERAGE (OHC) CODES CHART

OHC Code	Carrier
A	Any carrier
B	Blue Cross of California
C	Champus (HMO)
D	Prudential
E	Aetna
F	Medicare HMO
G	General American
H	Mutual of Omaha

OHC Code	Carrier
I	MetraHealth
J	John Hancock Mutual Life Insurance
K	Kaiser (HMO)
L	Dental-only policies
M	Multiple coverage (recipient has more than one insurance policy)
N	None
O	Override
P	PHP/HMO
Q	Undefined
R	Undefined
S	Blue Shield of California
T	Travelers Plan Administrators (only)
U	CIGNA/Connecticut General/Equicor
V	Coverage other than those specified (variable)
W	Great West Life Assurance Co.
X	Blue Shield of California
Y	Undefined
Z	Blue Cross of California
2	Health Source Provident Administrators

OHC Code	Carrier
3	Principal Financial Group/ Principal Mutual
4	Pacific Mutual Life Insurance
5	First Health/Alta Health
6	American Association of Retired Persons (AARP)
7	Undefined
8	New York Life Insurance
9	Healthy Families (HF) Program

Unless a provider is authorized under 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 Health 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 Health's liability, the provider must obtain an acceptable denial letter from the HMO.

6. **Scope of coverage codes**
The CalOptima Health eligibility verification system returns the scope of coverage code when coverage information is available to 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

COV Code	Service Category	Bill On (Claim Type)
P	Prescription drugs/medical supplies	Pharmacy Claim Form (30-1) or CALPOS
L	Long-term care	Payment Request for Long-Term Care (25-1)
I	Hospital inpatient	UB-04 Claim Form
O	Hospital outpatient	UB-04 Claim Form
M	Medical and allied services	CMS-1500 Claim Form

COV Code	Service Category	Bill On (Claim Type)
V	Vision care services	Payment Request for Vision Care and Appliances (45-1)
D	Dental services	Not applicable to EDS claims
Comprehensive	Coverage for all medical services except for Long-term care and dental	As appropriate

If information about a recipient's insurance scope of coverage is not available to DHCS, the message "COMPREHENSIVE" is returned from the CalOptima Health 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 Health.

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 Health after OHC

These principles must be followed when billing CalOptima Health after OHC:

a. The OHC benefit must be used completely.
b. CalOptima Health may be billed for the balance, including OHC copayments, coinsurance and deductibles.
c. CalOptima Health will pay up to the limitations of the CalOptima Health program, less the OHC payment amount, if any.
d. CalOptima Health will not pay the balance of a provider's bill when the provider has an agreement with the OHC 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 OHC must accompany the CalOptima Health claim, except for pharmacy providers.
f. The amount, if any, paid by the OHC carrier for all items listed on the CalOptima Health 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. OHC EOB or Denial Letter

a. When billing CalOptima Health for any service partially paid or denied by the recipient's OHC, the OHC EOB or denial letter must accompany the claim.
b. When a service or procedure is not a covered benefit of the recipient's OHC, 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. OHC code F identifies CalOptima Health recipients who receive benefits from:

i. Medicare HMO
ii. Medicare-contracted HMO in lieu of Medicare fee-for-service

Recipients who have CalOptima Health and Medicare HMO coverage must seek medical treatment through their Medicare HMO. CalOptima Health 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 Health claims for recipients with Medicare HMO coverage are not Medicare/CalOptima Health crossover claims. Therefore, to bill CalOptima Health for services not included in the Medicare HMO plan, submit a CalOptima Health 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 Health Direct recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits.

CalOptima Health Direct recipients are considered Medicare-eligible if they are 65 years of age or older, blind or disabled, or if the CalOptima Health Direct eligibility verification system indicates Medicare coverage.
If Medicare approves the claim, it must then be billed to CalOptima Health as a crossover claim at:

CalOptima Health Crossover Claims Unit
P.O. Box 11070
Orange, CA 92856

For more information about where to submit Medicare crossover clams, please see **Section H5: Submitting Crossover Claims**.

BILLING FOR MEDICARE NON-COVERED, EXHAUSTED OR DENIED SERVICES, OR MEDICARE NON-ELIGIBLE RECIPIENTS

Straight CalOptima Health claims must be billed directly to CalOptima Health 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 Health maintains a list of Medicare Non-Covered codes that may be billed to CalOptima Health Direct claims for Medicare/CalOptima Health Direct recipients. Do not send these claims to the CalOptima Health Crossover Unit.

   All services or supplies on a straight CalOptima Health 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 Health Direct.

2. **Medicare exhausted services**
   Physical therapy and occupational therapy for CalOptima Health 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 Health 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 Health 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 Health 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 the 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 OHC 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 Health website at www.caloptima.org.
   g. Do not send these claims to the Crossover Unit.

5. **Services denied when included in surgical fee or for separately payable**
   CalOptima Health 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 Health Direct does not pay for services denied by Medicare because the procedure is a component part of a group of services. CalOptima Health 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 Health 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/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 Health 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), the provider must copy the Medicare denial description(s) from the back of the original EOMB or from the Medicare manual. The provider must submit it to CalOptima Health 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 OHC before billing CalOptima Health 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 OHC, 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 OHC carrier.

3. **Last:** Bill CalOptima Health Direct. Attach the Medicare Explanation of Medicare Benefits/Medicare Remittance Notice (EOMB) and the other health coverage EOB to the CalOptima Health claim.

Please note that pharmacy providers are exempt from the requirement referenced above.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

CalOptima Health Policies and Procedures:

MA.3103: Claims Coordination of Benefits

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H8: COMMON CLAIM DENIALS AND REJECTS — CALOPTIMA HEALTH DIRECT, SHARED-RISK AND ONECARE (HMO D-SNP)

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

EOC	DESCRIPTIONS	BILLING TIPS
CDD	Duplicate claim	Claim received for the same member, same services and same date of service. Be sure to check previous payment record (Remittance Advice) before rebilling the original claim. To inquire about the status of a claim, call our Claims Provider Support Unit at **714-246-8600**, from 8 a.m. to 4 p.m.
X18	This is a health network member	Member is eligible with a CalOptima Health health network at the time of service. Be sure to check eligibility prior to submitting the claim to CalOptima Health Direct.
726	Bill Medicare, send EOMB and claim to EDS	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 Health Direct. If the service was paid by Medicare, send the EOMB and claim for crossover processing.
728	Proof of payment/denial required	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.
S13	All enroll events are future	Member is not eligible to receive CalOptima Health benefits for the date of service billed. Verify member eligibility through AEVS or POS.
748	Claim received after one-year maximum billing limit	Claims must be received by CalOptima Health within one year from the date on which services were rendered. Be sure to avoid timeliness denial. To inquire about the status of a claim, call our Claims Provider Support Unit at **714-246-8600** from 8 a.m. to Noon and 12:30 p.m. to 4 p.m.

COMMON CLAIMS DENIAL REASONS — ONECARE (HMO D-SNP)

The OneCare Claims department is responsible for processing claims for facility services rendered to OneCare members. This section identifies several common reasons that may cause OneCare Claims department to deny a claim.

When the OneCare 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.

EOC	DESCRIPTIONS	BILLING TIPS
CDD	Duplicate claim	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 rebilling the original claim. To inquire about the status of a claim, the provider can contact OneCare's Claims Provider Support Unit at **714-246-8600**, Monday through Friday from 8 a.m. to Noon and 12:30 to 4 p.m.
XON	No authorization	The claim has been denied because the service was not authorized. The provider should refer to the member's ID card for authorization requirements.
MDC	Rebill Medicare codes	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 rebill the claim with the appropriate Medicare code.
G01, G09	Group's responsibility	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.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H9: RECONCILING CALOPTIMA HEALTH DIRECT AND ONECARE PAYMENTS

This section provides information on the importance of reconciling CalOptima Health Direct claims payments to a provider's records. Providers receiving a CalOptima Health Direct Remittance Advice Details (RADs) statement should reconcile each claim transaction to their records. In particular:

- Paid claims should be posted to the member'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 to 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 Health 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 Health Direct
    P.O. Box 11037
    Orange, CA 92856

    b. CalOptima Health 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 Health. 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 Health Direct Claims line at **714-246-8600** 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 Health Direct address noted above. Please be sure to include a request for the check to be reissued. CalOptima Health Direct will initiate a search for the check.
    d. If the search shows the missing check was canceled, CalOptima Health 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 redeposited into a suspense account. The claim lines appearing on the redeposited check are voided to correct history and reduce the 1099 earnings amount.
    b. If the check was redeposited inadvertently and the claim lines are voided, a provider must rebill to receive payment and advise CalOptima Health of his or her correct address. The provider should contact the Provider Relations department at **714-246-8600**.

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 reissued 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 redeposited 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 rebill the claim for reprocessing.

3. **Misdirected Remittance Advice Details (RADs) and Checks**
   a. CalOptima Health 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 Health Direct and forward with the RAD to:

      CalOptima Health Direct
      P.O. Box 11037
      Orange, CA 92856

   b. For CalOptima Health's OneCare program, the provider can return funds to OneCare by sending a check to OneCare along with the Remittance Advice Details statement to:

      OneCare (HMO D-SNP)
      P.O. Box 11065
      Orange, CA 92856

4. **Retain Original Remittance Advice Details (RADs)**
   a. The CalOptima Health Direct RADs you receive with each check write are the only record of CalOptima Health Direct claims adjudication you will be sent. Retain original RADs for future reference.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H10: NDC BILLING GUIDELINES FOR CALOPTIMA HEALTH 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), 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:

Package NDC	Zero Fill	11-digit NDC
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2	(00002- 0022- 02)	00002002202

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.

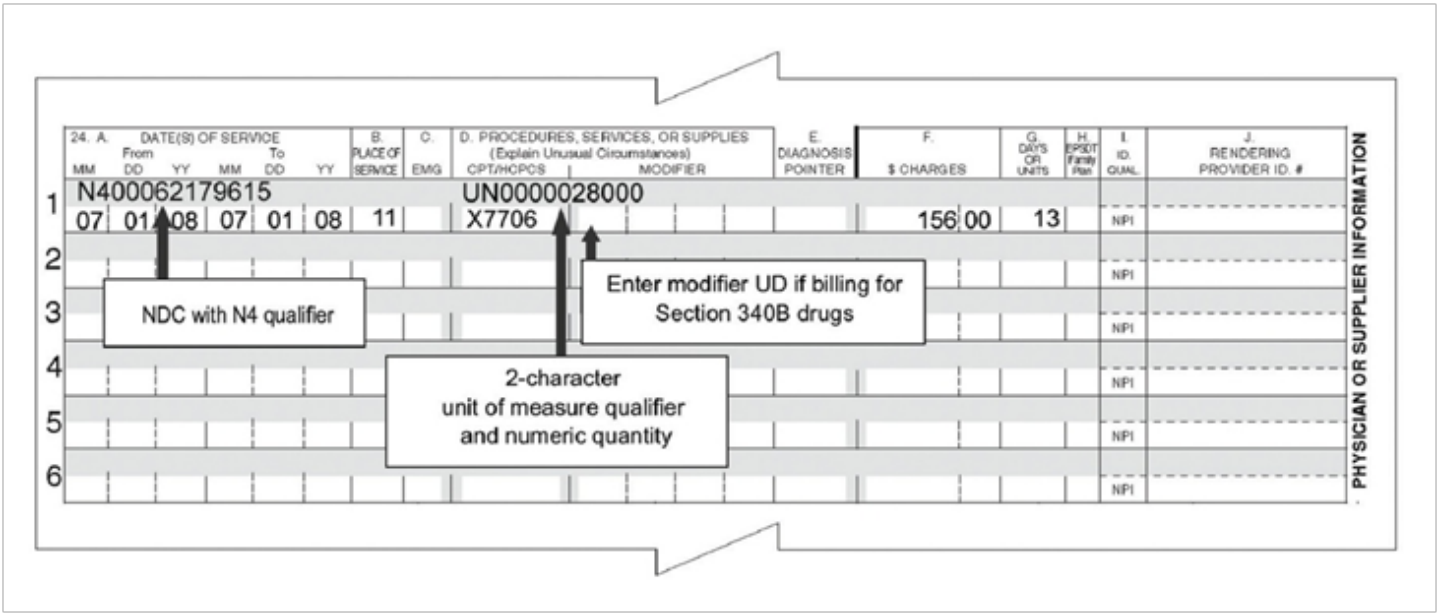
Box 24D: Unit of Measure — Qualifier and Quantity

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:

Qualifier	Unit of Measure
F2	International Unit

Qualifier	Unit of Measure
GR	Gram
ML	Milliliter
UN	Unit

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 that are 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.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H11: PROVIDER DISPUTE RESOLUTION PROCESS: CALOPTIMA HEALTH DIRECT AND SHARED RISK CLAIMS

CalOptima Health offers the Provider Dispute Resolution Request (PDR) process for providers to resolve issues involving claims submitted to CalOptima Health. **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 Health website at www.caloptima.org.

2. Send Completed Provider Dispute Resolution Request forms to:

   CalOptima Health
   Attention: Claims Provider Dispute
   P.O. Box 57015
   Irvine, CA 92619

3. Provider disputes should be sent within one year of the last determination for timely consideration.

4. CalOptima Health 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 Health to ensure that best practices are used for proper feedback and resolution of claim payment/denial discrepancies.

CalOptima Health's Claims Provider Dispute Process should be used prior to filing a Complaint with CalOptima Health'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.**

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

CalOptima Health Policies and Procedures:

FF.2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct Members or Members Enrolled in a Shared Risk Group

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H11: PROVIDER DISPUTE RESOLUTION PROCESS: ONECARE CLAIMS

OneCare 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 are directly responsible for adjudicating claims for facility services rendered to OneCare members. For disputes regarding claims filed with the member's OneCare health network, providers should contact the health network directly.

FILING A PROVIDER DISPUTE RESOLUTION FOR CLAIM ISSUES

1. **Submitting the OneCare Provider Dispute Resolution Request to OneCare:**
   Please send the completed OneCare Provider Dispute Resolution Request form to:

   CalOptima Health OneCare (HMO D-SNP)
   Claims Provider Dispute
   P.O. Box 11065
   Orange, CA 92868

2. **Filing Within the Required Time Frame and Next Steps:**
   a. Provider disputes must be submitted to OneCare within 365 days of the most recent determination/action for the claim.
   b. OneCare 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.
3. The Provider Dispute Resolution process has been put into place for OneCare to ensure that best practices are used for proper feedback and resolution of payment/denial or contested claim discrepancies.

4. The Provider Dispute Resolution process should be used prior to filing a formal appeal to CalOptima Health'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.**

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H12: MEMBER BILLING RESTRICTIONS

The Department of Health Care Services (DHCS) and CalOptima Health have specific guidelines restricting the billing of CalOptima Health 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

DHCS prohibits providers from charging members for Medi-Cal-covered services or having any recourse against the member or DHCS for Medi-Cal-covered services rendered to the member.

- The prohibition on billing of 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, sports physical forms, or history or physical forms that are required by a school, medical forms for Department of Motor Vehicles (DMV) requirements, PM160 Well-Child Visit form, lead testing questionnaire and forms related to Medi-Cal eligibility.) Please refer to Policy AA.1220 for additional information.

- A provider who accepts a member as a patient must accept payment in full from CalOptima Health, 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:

- The member agrees to the fees in writing prior to the actual delivery of the non-covered services
- A copy of the written agreement is provided to the member and placed in his or her medical record
- The rendering provider is not registered with Medi-Cal.

FACTS ABOUT THE MEMBER BILLING RESTRICTIONS

- Providers should always verify a CalOptima Health member's eligibility prior to rendering covered services and, if applicable, obtain appropriate prior authorization in accordance with CalOptima Health Policies and Procedures.
- 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 Health member or the member's representative for covered services.
- 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 Health member or the member's representative for authorized, urgent or emergent covered services.

- Providers should not collect payment (check, cash or credit card) for services rendered in lieu of billing a claim to CalOptima Health, its health network, medical group or third-party administrator.
- 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 in a timely manner.
- Providers should never ask a CalOptima Health 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 Health.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

CalOptima Health Policies and Procedures:

AA.1220: Member Billing

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

H12: 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

- Providers contracted with OneCare health networks cannot bill OneCare 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 its contracted health network.

- 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, sports physicals forms, or history of physical forms that are required by a school, medical forms for Department of Motor Vehicles (DMV), PM160 Well-Child Visit form, lead testing questionnaire and forms related to Medicare and 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:

- The member agrees to the fees in writing prior to the actual delivery of the non-covered services.
- 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.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H13: 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 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. Medi-Cal will cover a sterilization 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:
    a. 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
    b. 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, will pass 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:
    a. The patient consented to the sterilization at least 30 days before the intended date of sterilization
    b. 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:
    a. The written informed consent was given at least 30 days before the expected date of delivery
    b. 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 claims for sterilization services. 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

- The informed consent process may be conducted either by a physician or by the physician's designee.
- 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 whether 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

- The only sterilization form accepted by Medi-Cal is the DHS Consent Form (PM330).
- Claims submitted with a computer-generated form or any other pre-printed version of the PM330 **will not** be reimbursed.
- The sterilization consent form requirements are imposed by the federal government in the California Code of Regulations, Title 22, Section 51305.4.
- The instructions for the form must be completed exactly as requested.
- 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

Members Seeking or Obtaining Abortions

- **Seeking to obtain** means the period of time during which the abortion decision and the arrangements for the abortion are being made.

- **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 (in English and Spanish) 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

The following CPT and HCPCS codes require a Sterilization Consent Form (PM 330) when the procedure will render the recipient sterile and unable to conceive: 55250, 58565, 58600, 58605, 58611, 58615, 58661,58670, 58671, 58700, 58720, and A4264.

QUESTIONS ABOUT STERILIZATION CONSENT

For further information regarding sterilization consent and procedures, contact CalOptima Health's Claims department at **714-246-8600**.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600** Monday through Friday, from 8 a.m. to Noon and 12:30 to 4 p.m.

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

I1: FORMULARY INFORMATION

CalOptima Health maintains a formulary for OneCare that list prior authorization requirements, quantity limits and step therapy edits. For Medi-Cal members, the California Department of Health Care Services (DHCS) has a Contract Drug List which details medication coverage and prior authorization requirements.

The CalOptima Health Pharmacy and Therapeutics Committee is responsible for development of the CalOptima Health OneCare formulary, which are based on sound clinical evidence. Therapeutic classes in the formulary are reviewed at least annually by the CalOptima Health Pharmacy and Therapeutics Committee, which consists of actively practicing CalOptima Health physicians and pharmacists. Quarterly updates to the CalOptima Health formularies are communicated via our website to both members and providers.

HOW TO ACCESS THE FORMULARY

You can access the CalOptima Health OneCare formulary on our website at www.caloptima.org/.

The Medi-Cal Contract Drug List can be found on the DHCS Magellan Rx website: https://medi-calrx.dhcs.ca.gov/.

This section applies to the following CalOptima Health programs:

Medi-Cal

I2: PHYSICIAN-ADMINISTERED DRUG (PAD) PRIOR AUTHORIZATION REQUIRED LIST INFORMATION

CalOptima Health reviews prior authorization requests for some drugs that are administered at the physician's office. CalOptima Health has a list of drugs that require prior authorization. This list is called the Physician-Administered Drug Prior Authorization List (PAD PA List). CalOptima Health maintains the PAD PA List for the Medi-Cal plan.

The CalOptima Health Pharmacy and Therapeutics Committee is responsible for the development of the CalOptima Health Medi-Cal PAD PA List, which is based on sound clinical evidence. Therapeutic classes are reviewed at least annually by the CalOptima Health Pharmacy and Therapeutics Committee, which consists of actively practicing CalOptima Health physicians and pharmacists. Quarterly updates to the CalOptima Health Medi-Cal PAD PA List are communicated via our website.

In some instances, CalOptima Health's Medi-Cal PAD PA List may include specific medications that a physician may want to prescribe for a member. A physician can submit a prior authorization request for a medication that is listed on the PAD PA List.

Most medically necessary Food and Drug Administration (FDA)-approved drugs are potentially covered under the Medi-Cal medical benefit. CalOptima Health may cover those drugs listed on the PAD PA List with an approved prior authorization.

HOW TO ACCESS THE PAD PA LIST

You can access the CalOptima Health Medi-Cal PAD PA List on our website under the Prior Authorization webpage of the Providers section at www.caloptima.org.

HOW TO REQUEST PRIOR AUTHORIZATION FOR MEDI-CAL PHYSICIAN-ADMINISTERED DRUGS

Complete an authorization request form and fax the completed form to **657-900-1649**. For more information on this process and a copy of the form, please visit CalOptima Health's website at www.caloptima.org, under the Prior Authorization webpage of the Providers section.

1. You may request a PAD prior authorization through the Provider Portal by visiting CalOptima Health's website at www.caloptima.org and following the instructions.

2. If you submit a PAD prior authorization form by fax, be sure to complete the form legibly. Illegible forms may result in processing delays, or CalOptima Health may return forms that are illegible or incomplete.

3. It is important to include documentation of appropriate clinical information that supports the medical necessity of the requested medication, quantity, frequency or duration of therapy. Also, document all previously tried drugs, along with the resulting clinical outcome.

4. Include any additional documentation requested by the reviewer to support medical justification (e.g., progress notes, specialty consult evaluations and recommendations, laboratory results, etc.).

This section applies to the following CalOptima Health programs:

OneCare

I3: PHARMACY PRIOR AUTHORIZATIONS

In some instances, CalOptima Health's OneCare formulary 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, does not meet a step therapy or quantity limit, or does not meet a duration-of-therapy limit listed on the formulary.

HOW TO REQUEST PRIOR AUTHORIZATION FOR ONECARE

Complete a OneCare pharmacy prior authorization request form and fax the completed form to **858-357-2556**. For more information on this process and a copy of the form, please visit CalOptima Health's website at www.caloptima.org.

1. You may request a pharmacy prior authorization by phone by calling **CalOptima Health's pharmacy benefit manager** at 800-819-5532 and following the automated instructions.
2. You may request a pharmacy prior authorization by phone by calling CalOptima Health's Pharmacy department at **855-584-8672**.
3. You may request a pharmacy prior authorization through the ePA program via the member's electronic medical record (EMR/EHR) or available connectivity portals.
4. You may request a pharmacy prior authorization online using the web submission form located on CalOptima Health's website at www.caloptima.org.
5. 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 Health may return forms that are illegible or incomplete.
6. 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.
7. Include any additional documentation requested by the reviewer to support medical justification (e.g., progress notes, specialty consult evaluations and recommendations, laboratory results, etc.).

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

I4: MEDICATION THERAPY MANAGEMENT PROGRAM

The OneCare Medication Therapy Management (MTM) program, also known as the Medicine Review 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 MTM program is to achieve optimal outcomes of drug therapy by identifying, resolving and preventing medication-related problems.

On a quarterly basis, CalOptima Health 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
    - Chronic obstructive pulmonary disease (COPD)
    - Hypertension
    - Hyperlipidemia
    - End-stage renal disease (ESRD): This is determined from a prescription claim or diagnosis.
2. Are receiving eight or more medications per quarter
3. Are projected to exceed the Centers for Medicare & Medicaid Services (CMS) defined threshold in pharmacy expenditures annually

Due to the growing concern regarding the overutilization of opioids in the treatment of patients with chronic pain not associated with cancer, Part D plans have been encouraged to offer MTM services to members who are at risk of adverse events due to opioid overutilization, but do not otherwise qualify for MTM.

MTM services are now being offered to members who meet the Overutilization Monitoring System (OMS) criteria. OMS criteria are determined by CMS annually to identify Part D members who CMS believes are at the highest risk of adverse events or overdose due to total cumulative morphine milligram equivalents (MME) of 90 mg or more during the past six months, obtaining opioids from multiple unique prescribers and/or pharmacies, and/or recent history of opioid overdose. Members with active cancer-related pain, in hospice, receiving palliative or end-of-life care in a long-term care facility, or with sickle cell disease are exempt from OMS criteria.

The Part D Drug Management Program will identify at-risk and potentially at-risk members. These identified members receive the same reviews and interventions as members who meet the specified MTM criteria 1–3 listed above.

HOW TO FIND OUT MORE ABOUT THE ONECARE MTM PROGRAM

The member's primary care provider (PCP) plays an important role in the provision and coordination of quality care to OneCare members. After a member has completed a medication review with a pharmacist, a letter will be faxed with recommendations to the member's PCP.

If you have questions about how best to coordinate the member's care in conjunction with the MTM program, contact our staff at **714-246-8471**.

This section applies to the following CalOptima Health programs:

OneCare

I5: PHARMACY NETWORK

CalOptima Health's pharmacy network includes more than 500 pharmacies in Orange County and surrounding areas. CalOptima Health maintains a printed directory of network pharmacies, as well as a listing of network pharmacies on its website. Each network pharmacy serves the CalOptima Health OneCare program.

For Medi-Cal pharmacy network information, visit the DHCS Medi-Cal Rx website: https://medi-calrx.dhcs.ca.gov/.

HOW TO LOCATE A CALOPTIMA HEALTH NETWORK PHARMACY

To find a nearby CalOptima Health OneCare network pharmacy, visit the Providers section of the CalOptima Health website.

The website contains three network listings — a listing that includes all network pharmacies, a listing of long-term care pharmacies and a listing of home infusion pharmacies.

This section applies to the following CalOptima Health programs:

Medi-Cal

J1: COMPLEX CASE MANAGEMENT

Case management is the coordination of care and services for members who are high risk or have experienced a critical event or diagnosis. 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 Health'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.

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 Health Direct (COHD) and CalOptima Health Community Network (CHCN) members:** If a provider identifies a CalOptima Health member needing case management, the provider can make a direct referral to CalOptima Health's Case Management department by emailing cmtriage@caloptima.org.

2. **CalOptima Health 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 Health Department and Program Contact Information**.

If a provider has questions about CalOptima Health's Case Management program, call CalOptima Health's Customer Service department at **714-246-8400**.

CalOptima Health Policies and Procedures:

GG.1301: Case Management Process

This section applies to the following CalOptima Health programs:

Medi-Cal

J2: CASE MANAGEMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

CalOptima Health 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 disorders, 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 wellbeing
5. Improve the member's quality of life
5. Provide transition planning

Emphasis on coordination

With proper identification of children with special health care needs, along with health risk assessments and development of individualized care plans, CalOptima Health'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 Health's ability to case manage children with special health care needs, primary care providers should perform an initial health appointment within 120 days of enrollment for each new member under age 21. CalOptima Health uses the initial health appointment 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 CalOptima Health's Customer Service department at **714-246-8400**.

HOW TO MAKE A REFERRAL

CalOptima Health Direct (COHD) and CalOptima Health Community Network (CHCN) members: If a provider identifies a CalOptima Health COHD or CHCN member with special health care needs, the provider can make a direct referral to CalOptima Health's Case Management department by emailing cmtriage@caloptima.org.

CalOptima Health 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 Health 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 Health Department and Program Contact Information.**

This section applies to the following CalOptima Health programs:

Medi-Cal

J3: END-STAGE RENAL DISEASE (ESRD) CASE MANAGEMENT

CalOptima Health case manages members with end-stage renal disease (ESRD) on dialysis. This function is not delegated to any of CalOptima Health's health networks (**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 Health Community Network (CHCN) — Because members with ESRD have unique and specialized health care needs, members with ESRD are transferred from their health network into CalOptima Health Community Network.

HOW TO REFER MEMBERS WITH END-STAGE RENAL DISEASE

1. If a provider identifies a member who has ESRD, 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. Send the completed form to the member's health network. For CalOptima health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.

2. The member's health network will work with CalOptima Health's Case Management department to transition the member to CalOptima Health Community Network.

3. If a provider identifies a CalOptima Health Direct or CHCN member with newly diagnosed ESRD, the provider should contact CalOptima Health's Case Management Department by emailing cmtriage@caloptima.org.

This section applies to the following CalOptima Health programs:

Medi-Cal

J4: HEMOPHILIA CASE MANAGEMENT

CalOptima Health case manages any Medi-Cal member with hemophilia. This function is not delegated to any CalOptima Health 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 Health Community Network — Because members with hemophilia have unique and specialized health care needs, members with hemophilia are transferred from their health network into CalOptima Health Community Network.

HOW TO REFER MEMBERS WITH HEMOPHILIA

- If a provider identifies a member who has hemophilia, and the member is enrolled in a CalOptima Health health network, the provider should contact the member's health network immediately. For health network contact information, see **Section B1: CalOptima Health Department and Program Information.**
  The member's health network will work with CalOptima Health's Case Management department to transition the member to CalOptima Health Community Network.

- If a provider identifies a new member with hemophilia who is in CalOptima Health Direct or CalOptima Health Community Network, the provider should contact CalOptima Health's Case Management department by emailing WCMhemophiliainbox@caloptima.org.

CalOptima Health Policies and Procedures:

GG.1318: Coordination of Care for Hemophilia Members

This section applies to the following CalOptima Health programs:

Medi-Cal

J5: TRANSPLANT CASE MANAGEMENT

CalOptima Health case manages potential transplant patients. This function is not delegated to any CalOptima Health health network (HMO, PHC or Shared Risk Medical Group).

CalOptima Health's transplant program — CalOptima Health's transplant case management program provides the resources and education needed to proactively manage members identified as potential transplant candidates.

A CalOptima Health case manager works in conjunction with contracted providers and the DHCS Transplant Center of Excellence (COE) to assist members through the transplant review process. CalOptima Health's case managers monitor patients on an inpatient and outpatient basis, assisting the member, their physician and the 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

3. For Whole Child Model members, medically necessary blood, tissue and solid organ transplants are performed by a California Children's Services-approved Special Care Center.

Transplant patients are assigned to the CalOptima Health 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 CCN after they are "listed" and are awaiting procurement of an available organ.

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 Health HMO, PHC or Shared Risk Medical Group health network, the provider should contact the member's health network immediately.

1. The member's health network will work with CalOptima Health's Case Management department to transition the member to CCN and to identify an appropriate transplant center.

2. If a provider identifies a member who may need a transplant and who is enrolled in COD or CCN, the provider can reach CalOptima Health by fax at **714-796-6607** or send an email to cmtriage@caloptima.org.

CalOptima Health Policies and Procedures:

GG.1105: Coverage of Organ and Tissue Transplants

GG.1313: Coordination of Care for Transplant Members

This section applies to the following CalOptima Health programs:

OneCare

J6: REFERRING MEMBERS FOR CASE MANAGEMENT

Case management is the coordination of care delivery and services for members, either within or across delivery systems, including services members receive from CalOptima Health and community and social support providers. Care coordination services are included in basic case management, care coordination, complex case management and Enhanced Care Management (ECM)-like. Care coordination also involves deliberately organizing member care activities and sharing information among all of those involved with patient care.

OneCare'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's health network case management support is available for all members with a focus on the most vulnerable members of OneCare.

Most Vulnerable Members:

1. ECM-like Members: Members who meet the eligibility criteria for the Medi-Cal ECM Population of Focus.
    - Adults and their families experiencing homelessness
    - Individuals at risk for avoidable hospital or emergency department admission
    - Individuals with serious mental illness and/or SUD
    - Individuals at risk for institutionalization or long-term care

2. Individuals eligible for palliative care: Members using the Medi-Cal palliative care general and disease-specific eligibility criteria.

3. Homebound individuals

4. Individuals with cognitive impairment, Alzheimer's or dementia; defined by using ICD-10 diagnostic codes for dementias, Alzheimer's and senile degradation of the brain.

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 health network. For OneCare health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.

This section applies to the following CalOptima Health programs:

OneCare

J7: MODEL OF CARE

OVERVIEW

CMS requires all Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC). The SNP Model of Care is CalOptima Health'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 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 factors, cognitive factors, environmental factors, living conditions and co-morbid conditions of OneCare members
- Health conditions impacting OneCare members
- Unique characteristics of the OneCare population
- Identification of the most vulnerable members of OneCare

Description of OneCare Population: Most Vulnerable Members

OneCare has identified the following special populations:

- ECM-like Members
    a. Adults and their families experiencing homelessness
    b. Individuals at risk for avoidable hospital or emergency department admission
    c. Individuals with serious mental illness and/or SUD
    d. Individuals at risk for institutionalization or long-term care
- Individuals eligible for palliative care
- Homebound individuals
- Individuals with cognitive impairment, Alzheimer's or dementia

CARE COORDINATION

Care coordination is defined as the following:

- **OneCare Staff Structure** — Administrative and clinical roles specific to OneCare
- **Health Risk Assessment Tool (HRA)** — Assessment of the OneCare member's health needs
- **Face-to-Face Encounter** — In person or an interactive telehealth visit involving the OneCare member and a participant of their Interdisciplinary Care Team
- **Individualized Care Plan (ICP)** — A plan of care for the OneCare member based on information from the HRA
- **Interdisciplinary Care Team (ICT)** — A team of medical, behavioral and ancillary providers, plus the OneCare member and an authorized representative

- **Care Transition Protocols** — Guidelines on how to manage the OneCare member across the care continuum
- **Medi-Cal ECM** — ECM-like care management services provided through the OneCare program

Care Coordination: Staff Structure and Roles

OneCare staff is organized to align with essential care management roles:

- Administrative staff
- Clinical staff

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

Clinical Roles

OneCare clinical roles:

- Direct and oversee member care
- Provide education on self-management techniques
- Perform care coordination
- Provide pharmacy consultation
- Provide behavioral health counseling

Care Coordination: HRA

OneCare HRA:

- CalOptima Health OneCare administers initial (90-day) and an annual HRA for each member.
- OneCare uses a standardized HRA tool.
- HRA is used to evaluate the medical, functional, cognitive, psychosocial and mental health needs.
- Results are used to develop the member's ICP.
- HRA may be face-to-face, telephonic, electronic or paper-based.
- HRA identifies care needs that are categorized into care domains: Physical Health, Behavioral Health, Long-Term Services and Supports (LTSS), Access to Care, Care Coordination and promotion of Self-Management/Health and Wellness Monitoring.

Care Coordination: Face-to-Face Encounter

The face-to-face encounter is conducted in person. It is also available via an interactive telehealth visit based on the preference of the member. The PCP is primarily accountable for the face-to-face encounter. The member's PCP or specialist serving as the PCP conducts the face-to-face encounter for the delivery of health care services. The face-to-face encounter at a minimum involves the OneCare member and a participant of their ICT or CalOptima Health's case management team or designee.

Care Coordination: Individualized Care Plan

OneCare ICP:

- The ICP is the person-centered plan of care that incorporates the member's specific physical health, behavioral health, functional needs, cognitive functioning, social health, support system, resource needs and personal health care preferences.
- The ICP includes prioritized, personalized and measurable goals to meet a member's specific needs.
- The ICP comprehensively integrates information from the HRA, the member's risk care level, historical utilization and case management data, comprehensive assessments, LTSS/Community Supports, identified barriers to care and the member's main health concern to develop the plan of care.
- The ICP goals will be reassessed at least annually, upon identification of changes in the member's health care status or to address barriers to meeting care planning goals.
- OneCare supports the development, implementation and ongoing monitoring and modification of a member's ICP through an ICT process, in conjunction with the member and/or their caregiver and providers.
- The ICP is maintained in the clinical documentation platform.
- The ICP is considered part of the member's case management record and stored in accordance with HIPAA and in compliance with state, federal and HIPAA requirements.
- The ICP is shared with the member, PCP and applicable participants of the ICT initially and as part of the members ongoing care and coordination.

Care Coordination: Interdisciplinary Care Team

OneCare ICT:

- Facilitates the participation of the member, their caregiver or authorized representative in the development of their ICP
- Supports member's right to self direct care
- Ensure member's holistic needs are identified
- Facilitates linkage to appropriate LTSS
- Improves member/provider engagement, satisfaction and communication
- Prevents duplication of services
- Prevents transition to a higher level of care
- Closes gaps in care through communication with the ICT participants

The ICT is a structured collaborative process that includes their PCP, case manager and other disciplines, as appropriate.

- All members receive informal ICTs with all ICT participants contributing to the development and coordinating to the implementation of the ICP.
- All coordination and communication are documented in the clinical documentation platform, and the ICP is updated accordingly.
- Formal ICT meetings will be held and include all ICT participants as appropriate for requesting members or PCP, members stratified as high-risk, and members identified in a vulnerable population.
- Formal ICT meeting core participants include the member, PCP, case manager, social worker, care coordinator and medical director.
- Additional participants such as the behavioral health specialist, clinical pharmacist, dietician, LTSS coordinator, utilization management nurses, facility discharge planners, palliative care team, dementia care specialists, therapists and community-based organizations may be included in the ICT based on the member's specific needs.

Care Coordination: Care Transition Protocols

OneCare Transitions Program addresses comprehensive biopsychosocial care needs before, during and after a transition to prevent readmissions and ensure safe and coordinated care across the care continuum.

Care Coordination: Medi-Cal Enhanced Care Management

OneCare members needing case management services through D-SNPs may also meet the criteria for the Medi-Cal ECM Population of Focus. OneCare members who meet the criteria for the Medi-Cal ECM Population of Focus will be offered to receive ECM-like care management services provided through the OneCare program to streamline coordination to a single point of contact and eliminate duplication of effort if a member receives both programs.

PROVIDER NETWORK

Provider network includes:

- PCP
- Specialized expertise such as:
    a. Specialists
    b. Hospitalists
    c. SNF providers
    d. Allied health providers
    e. Behavioral health providers
    f. Community-Based Adult Services
    g. Multipurpose Senior Service Program
    h. In-Home Supportive Services
    i. Long-term care institutional services
    j. Pharmacists
    k. Crisis teams
    l. Ancillary services
    m. Community-based palliative care providers
- Facilities such as:
    a. Acute inpatient facilities including behavioral health
    b. Dialysis centers
    c. Post-acute hospital facilities including SNFs and long-term care
    d. Specialty outpatient clinics
    e. Residential care facilities
    f. Rehabilitation facilities
    g. Radiology and imagining facilities
    h. Laboratory facilities
- 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

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

Quality measurement (QM) and performance improvement (PI) are evaluated by:

- 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 coordination of care
- Appropriate utilization of services for preventive health and chronic conditions
- Improve member experience
- Enhanced care transitions across all health care settings and providers

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 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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

J8: CONTINUITY OF CARE

OVERVIEW

CalOptima Health is required to provide continuity of care as set forth in a Memorandum of Understanding (MOU) by CMS and DHCS.

CALOPTIMA HEALTH CONTINUITY OF CARE REQUIREMENTS

In order to meet continuity of care requirements, CalOptima Health must:

- Ensure members have access to medically necessary items and services, as well as medical and 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 in initiating the continuity of care process at that time if the member wishes to do so
    a. If the criteria are met, 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

Upon request by the member, their authorized representatives or their treating providers, CalOptima Health must offer continuity of care with an out-of-network provider to all OneCare members if the following circumstances exist:

- The member has an existing relationship with a 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.
- The provider is willing to accept payment from CalOptima Health based on the current Medicare or Medi-Cal fee schedule, as applicable.
- CalOptima Health 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 and later reenrolls, the continuity of care period starts over. CalOptima Health is required to provide continuity of care with an out-of-network provider for a 12-month continuity of care period based on the date of reenrollment regardless of whether the member received continuity of care in the past. If the member disenrolls and later reenrolls a second time (or more), the continuity of care period does not start over and CalOptima Health is not required to provide continuity of care again.

Provider Referral for Out-of-Network Providers

An approved out-of-network provider must work with CalOptima Health and cannot refer the member to another out-of-network provider without authorization from CalOptima Health. In such cases, CalOptima Health will make the referral if medically necessary and CalOptima Health does not have an appropriate provider within its network.

DME, Transportation and Other Ancillary Services

For DME, transportation and other ancillary services such as medical supplies, CalOptima Health must provide continuity of care for services, but is not obligated to use out-of-network providers that are determined to have a preexisting relationship, for the applicable six or 12 months.

Continuity of Care for Long-Term Care Facilities

OneCare 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 CDPH, meets acceptable quality standards and the nursing facility and CalOptima Health agree to Medi-Cal and/or Medicare rates.

Additional Continuity of Care Provisions

CalOptima Health must also allow OneCare members to have continued use of any single-source drugs that are part of a prescribed therapy by a contracting or non-contracting provider in effect for the member immediately prior to the date of enrollment. This applies whether or not the drug is covered by CalOptima Health, until the prescribed therapy is no longer prescribed by the contracted physician.

Additional requirements pertaining to continuity of care require CalOptima Health, at the request of the member, to provide for the completion of covered services by a terminated or non-participating CalOptima Health provider. CalOptima Health is required to complete services for the following conditions: acute conditions, serious chronic conditions, 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 Health must allow for the completion of these services for certain time frames, which are specific to each condition.

CalOptima Health Policies and Procedures:

CMC.6021a: Continuity of Care for New Members

GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

MA.6021 Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners

MA.6021a: Continuity of Care for New Members

This section applies to the following CalOptima Health programs:

Medi-Cal

K1: CHILD PROTECTIVE SERVICES

CalOptima Health 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 Health Policies and Procedures:

GG.1706: Child Abuse Reporting

This section applies to the following CalOptima Health programs:

Medi-Cal

K2: LOCAL EDUCATION AGENCY SERVICES

Local education agencies (LEAs) provide certain medically necessary preventive, diagnostic, therapeutic and rehabilitative services for children ages 3 years and older with special health care needs. A child may receive services from his or her LEA in accordance with the child's individualized education plan or individual family service plan.

What services are provided by an LEA? An LEA's 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
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. Targeted case management services
14. BHT

Neither CalOptima Health nor its health networks are responsible for the provision or payment of LEA services. However, CalOptima Health is responsible for providing a PCP and all medically necessary covered services for the member. CalOptima Health will also ensure the member's PCP cooperates and collaborates in the development of the individual education plan or the individual family service plan. CalOptima Health will 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 PCP participation.

IMPORTANT REMINDERS FOR PCPS ABOUT COORDINATING WITH LEAS

1. PCPs have an opportunity to identify CalOptima Health members who may be eligible for LEA services during pediatric preventive screenings, developmental screenings and case management referrals.

2. PCPs should refer members to the RCOC.

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 LEA services for the child through the RCOC.

5. For more information about LEA services, please contact the RCOC at 714-796-5100.

CalOptima Health Policies and Procedures:

GG.1321: Coordination of Care for Local Education Agency Services

This section applies to the following CalOptima Health programs:

Medi-Cal

K3: TUBERCULOSIS DIRECTLY OBSERVED THERAPY SERVICES

Providers are responsible for furnishing tuberculosis (TB) services to CalOptima Health 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)

Orange County HCA TB Control offers evaluation and treatment of individuals with active or suspected TB. Screening services (tuberculin skin testing, chest X-rays, symptom check and physician evaluation, when appropriate) are available 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 or unexplained weight loss
2. Persons with abnormal chest X-rays consistent with active TB
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 CDC Division of Global Migration and Quarantine 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, as well as CalOptima Health or the member's health network.

3. To report the case to the member's health network, see **Section B1: CalOptima Health Department and Program Contact Information** for a list of health network contact information. To report the case to CalOptima Health, contact CalOptima Health's Case Management department by emailing cmtriage@caloptima.org.

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 Health Policies and Procedures:

GG.1128: Tuberculosis Services

This section applies to the following CalOptima Health programs:

Medi-Cal

K4: WOMEN, INFANTS AND CHILDREN SERVICES

Low-income women and young children are eligible for services from WIC, a food and nutrition education program. WIC can reinforce and expand on the PCP's nutrition recommendations to help keep members at lower risk for health complications.

What Does WIC Services Include?

1. Healthy foods
2. Nutrition and health education
3. Referrals to health care and other community resources
4. Breastfeeding support and education

Who Is Eligible for WIC Services? The following people residing in Orange County may be eligible for WIC services:

1. Women who are pregnant, breastfeeding a baby up to 12 months of age, or had a baby or were pregnant within the past six months
2. Children up to 5 years of age (including foster children)
3. Families with low-to-medium income (working families may qualify)
4. Participants must be Medi-Cal eligible or meet WIC income eligibility levels

Neither CalOptima Health nor its health networks are responsible for the provision or payment of WIC services. However, as part of the referral process, providers will provide required medical documentation per WIC guidelines. PCPs, as part of their IHA for members or, as part of the initial evaluation of pregnant members, will 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

5. To make a referral, submit the referral to the WIC office using any of the following documents:
    a. WIC Referral for Pregnant Women
    b. WIC Referral for Postpartum/Breastfeeding Women
    c. Pediatric Referral
6. 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 months old), documentation of any nutrition-related risk factors, and other requested information in the WIC referral forms.
7. Instruct the patient to call a local WIC agency for an appointment at 888-YOUR-WIC or 888-968-7942.

For more information, patients and health professionals may call WIC at 1-888-942-9675 or visit www.cdph.ca.gov.

CalOptima Health Policies and Procedures:

GG.1703: WIC Referrals

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

K5: COORDINATION WITH COMMUNITY RESOURCES AND SOCIAL SERVICES

To help providers, especially primary care providers (PCPs), furnish patient-centered care, OneCare and their contracted health networks have the capability to refer members to local resources providing social and community services. In the course of serving OneCare members, providers may identify specific family, home environment, nutritional or other social needs that affect the member's health status. Many of these needs can be addressed with services available from community and social service agencies in Orange County.

OneCare and their 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, all CalOptima Health members can find information about other resources available by accessing the Members section of the CalOptima Health website. Listed below are two important examples of community resources available to members.

Aging and Disability Resource Connection (ADRC) — The ADRC is a collaborative effort led by the Orange County Office on Aging and the Dayle McIntosh Disability Resource Center. It is 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.

ADRC provides 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. ADRC programs work toward the goal of serving all individuals with long-term care needs, regardless of their age or disability.

For more information about ADRC, providers and members can visit their website at www.adrcoc.org or call 714-480-6450. Members can use the multilingual site to search by category, keyword, name, area served or location to find information on 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, 24/7, online and through their multilingual hotline. The website can be accessed at www.211oc.org/. Members can dial 2-1-1 to receive assistance with 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 Health 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 Health Department and Program Contact Information** of this manual.

For additional information regarding available community resources, visit CalOptima Health's website at www.caloptima.org or the County of Orange's Office on Aging website at Orange County Office on Aging.

CalOptima Health Policies and Procedures:

MA.6019: Coordination of Social Services

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

L1: PARTICIPATION IN CALOPTIMA HEALTH PROGRAMS

CalOptima Health members access their health care benefits and services through several delivery system models and programs. CalOptima Health members may access their health care benefits and services through a health network or through providers that are directly contracted with CalOptima Health and are part of CCN and COD. See **Section A1: CalOptima Health Programs and CalOptima Health's Delivery System**. All providers wishing to participate in CalOptima Health's programs must successfully pass CalOptima Health's credentialing requirements and meet the following criteria:

- The provider must be Medi-Cal enrolled.
- The provider's services must be available and accessible to CalOptima Health members residing in Orange County, California.
- The provider accepts CalOptima Health's reimbursement for CalOptima Health's Medi-Cal and Medicare (OneCare) programs.
  Have hospital privileges at a CalOptima Health contracted hospital or ambulatory surgical center if they perform surgical procedures.

PROVIDER PARTICIPATION

- **Contract with CalOptima Health**
  Providers interested in becoming a participating provider of CalOptima Health's Medi-Cal and Medicare programs may send a request to **CalOptima Health's Provider Relations department at** providerservicesinbox@caloptima.org to obtain more information on contracting with CalOptima Health. Provider requests must include:

  - Type of services provided
  - Service locations
  - Hospital privileges and/or ambulatory surgery centers (if applicable)
  - Medi-Cal-approval letter (DHCS letter)
  - Credentialing contact information to include name, title, address, phone/fax, email address
  - W-9
  - All applicable NPIs
  - For professional providers: roster of physicians participating in the group and their admitting privileges at CalOptima Health's participating hospitals
  - Any additional information you would like to include e.g., marketing flyer/brochure

Contract with a health network
If a physician or other provider is interested in contracting with one of CalOptima Health's health networks, the provider should contact the health network directly to inquire about contracting opportunities. For CalOptima Health health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.

Please feel free to go to CalOptima Health's website at https://www.caloptima.org/en/ForProviders/HowtoContractwithCalOptima for more information on how to become a contracted provider of CalOptima Health.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

L2: NON-CONTRACTED PROVIDER AND NON-CONTRACTED PRACTITIONER REGISTRATION

Providers and practitioners furnishing services to members of CalOptima Health Direct and CalOptima Health Community Network are required to register with CalOptima Health for claims review. Non-contracted providers and practitioners can register for the first time with CalOptima Health by completing the Provider Registration for Claim Submission, W9 and Tax Identification Number (TIN) forms. Existing non-contracted providers can make changes to their registration information by completing the Provider Demographic Changes form. All forms are located on our website at www.caloptima.org.

If you are interested in becoming a participating provider, see Section L1: Provider Contracting.

HOW TO REGISTER FOR POSSIBLE CLAIMS PAYMENT WITH CALOPTIMA HEALTH

Providers wanting to register must meet identified conditions and provide the following information:

1. Rendering provider active status with DHCS (Medi-Cal)
2. Rendering National Provider Identifier (NPI)
3. Completed W9, TIN form
4. Rendering provider state medical license
5. Rendering provider service address and phone number
6. Group name (if applicable)
7. Group National Provider Identifier (NPI) (if applicable)
8. Supervising physician name and license number (if applicable for non-physician medical practitioners)

HOW TO CHANGE AN EXISTING PROVIDER'S REGISTRATION INFORMATION

- Existing providers may change their registration information by:
    a. Emailing CalOptima Health Provider Data Management Services at provideronline@caloptima.org
    b. Faxing **714-954-2330**
- Changes a provider or practitioner may make to his or her registration information include:
    a. Terminations
    b. Additional addresses
    c. Phone/fax/email updates
    d. TIN changes (requires submission of a new W9 form)

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

M1: CREDENTIALING AND RECREDENTIALING

To help ensure a quality health care delivery system, CalOptima Health requires new providers (including physicians and non-physician medical practitioners) to be credentialed as part of the contracting process with CalOptima Health or one of its health networks. CalOptima Health also requires its providers to be recredentialed every three years.

Health Network Providers — CalOptima Health requires its contracted health networks to credential their own providers. As a result, providers wishing to participate with one of CalOptima Health'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**.

CCN Providers — If a provider intends to participate in CCN as a contracted provider, he or she must complete CalOptima Health's credentialing process or the credentialing process of one of our delegated provider groups.

Non-Physician Medical Practitioners (NMPs) — CalOptima Health and its health networks credential NMPs. NMPs must be supervised by a credentialed physician and under a delegation services agreement or standardized procedures. Physician supervision is not required for services rendered by nurse practitioners (NPs) who satisfy the requirements of California Business Professional Code (BPC), Sections 2837.103 and 2837.104. Physician supervision is also not required for services rendered by licensed midwives (LMs) and certified nurse midwives (CNMs).

Minimum Physician Standards — CalOptima Health requires all physicians to meet CalOptima Health's Minimum Physician Standards in accordance with CalOptima Health policy GG.1602. prior to completing a credentialing application for both CCN and delegated health networks.

Information Reviewed During Credentialing Process — In conducting the credentialing and recredentialing processes, CalOptima Health and its health networks verify specific information including, but not limited to, the following, as applicable:

- Credentialing application: This is an online tool used by many hospitals and health plans and is available at https://proview.caqh.org/PR/Registration
- California professional licensure
- Current professional malpractice liability insurance or proof of self-insurance
- Affiliations, such as hospitals, skilled nursing and long-term care facilities
- Exclusions, preclusion, suspensions or ineligibility to participate in any state or federal health care program
- Enrolled as a Medi-Cal provider, as required
- Valid Drug Enforcement Agency (DEA) certificate
- Education and training, including board certification
- Work history

Full Scope Facility Site Review (FSR) — In conjunction with the credentialing process, CalOptima Health also conducts a FSR, medical records review (MRR) and physical accessibility review survey (PARS) of all

new primary care sites, as required by DHCS. CalOptima Health conducts a full scope facility site review every three years for each primary care site. For more information on these reviews, 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 CCN must first contact CalOptima Health's Provider Resource Line at **714-246-8600**. CalOptima Health Provider Relations will notify CalOptima Health Credentialing of the provider's desire to participate in the CCN network. For practitioners not required to be credentialed and/or not having a corresponding state-level enrollment pathway, including but not limited to doulas, community health workers (CHW) and board-certified behavioral analysts (BCBA), CalOptima Health shall at minimum verify the qualifications and vet the practitioner in accordance with CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners.

Once Credentialing is notified of the provider's desire to participate, the provider will be asked to:

- Complete the CAQH online application, which is available at https://proview.caqh.org/PR/Registration This service is used by many hospitals and health plans and is free to the provider.
- After the provider has completed the CAQH application, the provider must "authorize" CalOptima Health to access the provider's application. If the provider is a current CAQH user, the authorization must be updated to include CalOptima Health so that CalOptima Health may access the provider's application.
- Additional documents will be emailed to the provider for completion and must be returned for credentialing to begin. These documents include:
    1. Minimum Physician Standards Questionnaire: For more information see CalOptima Health Policy GG.1643.
    2. HIV Specialist Screening Form (if applicable)
    3. Information Release Form
- The following documents will be requested from the provider and must be returned for credentialing to begin. These documents may include:
    1. Current W-9
    2. CV in monthly and year format
    3. Explanation for any gap (more than six months) in the education and/or work history or in between
    4. Malpractice insurance certificate
    5. California State Medical license
    6. DEA, if applicable
    7. Physician Assistant (PA) — Delegation of services agreement signed by your supervising physician. This physician must be presently credentialed with CalOptima Health and enrolled with Medi-Cal.
    8. NPs — Procedures and Protocols signed by your supervising physician. This physician must be presently credentialed with CalOptima Health and enrolled with Medi-Cal.

If the provider intends to contract as a primary care practitioner, CalOptima Health staff will contact the practitioner to schedule an initial facility site review. For more information, refer to **Section M2: Facility Site Review, Medical Record Review and Physical Accessibility Review Survey**.

If the practitioner is a high-volume specialist, CalOptima Health 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 Health will render a decision within 180 calendar days from the date the application attestation was signed, and all required documents were provided. The practitioner will receive an official letter of the credentialing decision.

HOW TO COMPLETE THE RECREDENTIALING PROCESS

- At the time of recredentialing (every three years after initial approved credentialing date) and if the practitioner has contracted with CCN, the provider will be contacted to confirm contact information of both the practitioner and his/her credentialing contact.
- If the provider has not yet completed the CAQH application, the provider will need to do so at re-credentialing. CAQH online application is available at https://proview.caqh.org/PR/Registration, and is free to the provider. Once the provider has completed the CAQH application, the provider must "authorize" CalOptima Health to access the application. Quarterly, CAQH will notify the provider to update and attest to the contents of the CAQH application.
- CalOptima Health 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**.

CalOptima Health will render a decision within 180 calendar days from the date the application attestation was signed, and all required documents are provided. The practitioner will receive an official letter of the recredentialing decision. For questions regarding the credentialing or re-credentialing process, call CalOptima Health's Provider Resource Line at **714-246-8600**.

CalOptima Health Policies and Procedures:

GG.1650: Credentialing and Re-credentialing of Practitioners

GG.1643: Minimum Physician Standards

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

M2: FACILITY SITE REVIEW, MEDICAL RECORDS REVIEW AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima Health 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 Department of Health Care Services (DHCS) FSR and MRR are conducted to ensure that all contracted PCP sites have sufficient capacity to:

- Provide appropriate primary care service.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices.
- Operate in compliance with all applicable local, state and federal laws and regulations.

CalOptima Health 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

- The FSR includes an on-site inspection, review of policies and procedures, and interviews with providers and office personnel.
- 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.
- The PARS surveys the facility site access to parking, the building, elevators, doctor's office, exam rooms and restrooms for members with disabilities. The survey will also identify if the site has a height adjustable exam table and/or accessible weight scale for those who need these accommodations.
- CalOptima Health will not review a site if:
    a. The PCP site has a current passing score on a survey conducted by another Medi-Cal managed care health plan.
- CalOptima Health has minimum standards for maintaining member medical records. Following are some of the required elements for maintaining member medical records. For more information on maintaining member medical records, refer to CalOptima Health 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 10 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 every entry in 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.

If deficiencies are identified during an FSR or MRR, a Corrective Action Plan (CAP) will be issued. The CAP will include specific time frames for addressing identified deficiencies. CalOptima Health will not allow provider sites with major uncorrected deficiencies to provide care to its members until the identified deficiencies have been corrected and the CAP has been submitted and approved.

For more information about the facility site review process, call CalOptima Health's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

M3: INITIAL HEALTH APPOINTMENT

DHCS Requirement
All members must receive an Initial Health Appointment (IHA) within 120 calendar days of enrollment with CalOptima Health for the Medi-Cal line of business. Providers must complete preventive services on all members as required by the American Academy of Pediatrics (AAP) for members less than 21 years of age. Providers will follow the most recent anticipatory guidance as outlined in the current AAP Bright Futures periodicity schedule. PCPs must complete all age-specific assessments and services according to the United States Preventive Services Task Force (USPSTF). For members under age 21, if a member, parent, guardian or case worker submits a request for preventive services during the first 120 days of the member's enrollment into CalOptima Health, an appointment must be made for a visit to take place within 10 working days.

What is the Initial Health Appointment?
The IHA is a comprehensive assessment completed during the member's first visit with their selected or assigned PCP, including OB/GYNs and specialists for members with special needs such as the SPD population. The purpose of the IHA is to assess and set the baseline for managing acute, chronic and preventive health needs of the member. The IHA must be provided in a way that is culturally and linguistically appropriate for the member.

Components of a Complete IHA:
- The IHA must be completed by the PCP within the primary care medical setting and include the following:
    - Comprehensive history, which includes a history of present illness, past medical history, social history and review of organ systems
    - Assessing and identifying risks, age-appropriate preventive screenings and referrals to appropriate services
    - Comprehensive physical and mental status exam
    - The diagnosis, health education and a plan for treatment of any disease

Identifying Members in Need of an IHA
Every month, CalOptima Health provides a list of newly enrolled members to:
- Providers via the Provider Portal identifying the IHA due date for each new member
- Each health network via a secure File Transfer Protocol (FTP) site for distribution among assigned PCPs

Codes for Documenting the IHA
(See Guide: https://www.caloptima.org/ForProviders/Resources/HealthEducation**)**
- IHA completion is documented using Current Procedural Terminology (CPT) codes.
- The IHA is a preventive service paid under current contract.
- In addition to submitting appropriate codes, providers must ensure they document primary care visits, child and adult preventive services, referrals for screenings, scheduled follow-ups, labs, missed appointments, and any member or caretaker refusal of the IHA in the member's medical record.

Tips for Meeting the IHA Requirement:
- Complete the IHA within 120 days of the member's effective date with CalOptima Health and code for all applicable services as identified in the components of a complete IHA above.

- Complete and code for the IHA as applicable during a sick visit, if any, during the first 120 days of enrollment.
- The IHA can be administered over the course of multiple visits, provided that all required components are completed within 120 days.

What Can Help?

- Use standardized documentation to make it easier to gather and track information on the IHA.
- Send in complete and accurate CPT codes.
- Contact members shown on your monthly new member lists whom you have not yet seen. Document all outreach attempts to schedule the IHA in the member chart.
- Members with unsuccessful IHA completions require a minimum of three documented outreach attempts. Examples may include a phone call, letter, or postcard.

CalOptima Health Policies and Procedures:

GG.1613: Initial Health Appointment

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

M4: CLINICAL PRACTICE GUIDELINES

CalOptima Health providers will follow evidence-based guidance by staying informed of current clinical practice guidelines. For your convenience, the clinical practice guidelines for conditions frequently seen in patients are available on the CalOptima Health website. Each guideline included on the website is connected to a link that will direct you to the appropriate content. All clinical practice guidelines included have been reviewed and approved by CalOptima Health's Quality Improvement Health Equity Committee. CalOptima Health is confident providers will find these clinical practice guidelines valuable to their daily practice.

RECOMMENDED CLINICAL PRACTICE GUIDELINES

Providers can view CalOptima Health's links to clinical practice guidelines on CalOptima Health's website at https://www.caloptima.org/en/ForProviders/Resources/ClinicalPracticeGuidelines.

CalOptima Health Policies and Procedures:

GG.1204: Clinical Practice Guidelines

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

M5: HEDIS MEASURES AND REPORTING

OVERVIEW

HEDIS stands for 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 measures across six domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- 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 & Medicaid Services (CMS) requirement that HMOs submit Medicare HEDIS data to provide HMO services for Medicare Advantage members.

CalOptima Health is required to report HEDIS rates to the DHCS, CMS and NCQA annually. Data obtained from HEDIS helps CalOptima Health to direct its quality improvement activities, evaluate performance and identify further opportunities for improvement. HEDIS measures are also selected by DHCS as quality measures for the Health Homes Program, Whole Person Care Program and Whole-Child Model Program.

Data Collection Methods

HEDIS measures are specified for one or more of four 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 a hybrid by NCQA, CalOptima Health also collects and reviews medical records.

- From late February to the end of April, 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 Health 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 Health to develop initiatives to improve the health of members based on 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, CalOptima Health maintains every member's confidentiality at the highest level following all Health Insurance Portability and Accountability Act (HIPAA) regulations.

HEDIS Tips for Practitioners

CalOptima Health contacts selected medical offices to review patient medical records as part of the HEDIS medical records review process. Here are HEDIS tips for physicians:

- Practitioners should keep accurate, legible and complete medical records for their patients. Each document in the medical record must contain the member's 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).
- 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.
- Since HEDIS reporting is mandated by the California DHCS, CMS and NCQA for compliance, practitioners and their staff should become familiar with HEDIS measures to understand what health plans are required to report.

FAQs Regarding Medical Record Collection

We submit claims and encounters; why does CalOptima Health 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.

What is my responsibility in the data collection process?

- HEDIS is a time-sensitive project. It is very important that providers respond to requests for medical record documentation in a timely manner to ensure CalOptima Health 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 Health 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 who 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.

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.

Is my participation in HEDIS data collection mandatory?

- Yes. All health networks, medical groups and medical offices that have provided services to CalOptima Health 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.

Should I allow a record review for a member who is no longer with CalOptima Health or for a member who is deceased?

- Yes. Medical record reviews may require data collection on services obtained over multiple years.

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.

Does HIPAA permit me to release records to a CalOptima Health representative or designated vendor for HEDIS data collection?

- Yes. As a CalOptima Health business associate, providers are permitted to disclose protected health information (PHI) to the contracted vendors who are acting on CalOptima Health's 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 Health 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:

What can I expect if my members 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 Health 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 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 Health 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 Health may call to confirm if the office has the appropriate information.

The HEDIS Documentation Requirements for Providers training covering the Measurement Year 2023 hybrid measures is posted on the CalOptima website:
https://www.caloptima.org/en/ForProviders/ProviderTrainings/HEDISHybridMedicalRecordReview.aspx

This training is updated annually, please complete the brief survey and let us know your feedback.

If providers have questions about HEDIS measures or data collection, email HEDISMailBox@caloptima.org or call CalOptima Health's Provider Resource Line at **714-246-8600**.

This section applies to the following CalOptima Health programs:

Medi-Cal

ACCESS STANDARDS

CalOptima Health adheres to patient care access and availability standards as required by DHCS and the Department of Managed Health Care (DMHC). DHCS and DMHC implemented these standards to ensure that Medi-Cal beneficiaries can get an appointment for care on a timely basis, reach the provider over the phone, and access interpreter services as needed.

Contracted providers and health networks are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards. CalOptima Health monitors its health networks and providers for compliance. CalOptima Health may develop corrective action plans for providers and health networks that do not meet these standards. Please refer to CalOptima Health Policy GG.1600: Access and Availability Standards for more information related to CalOptima Health's monitoring process.

UNDERSTANDING THE ACCESS STANDARDS

Please see below for a brief description of the access standards for CalOptima Health Medi-Cal members:

Appointment Standards:

Type of Care	Standard
Emergency Services	24/7
Urgent Appointments that DO NOT Require Prior Authorization	Within 48 hours of request
Urgent Appointments that DO Require Prior Authorization	Within 96 hours of request
Initial Health Appointment	Within 120 calendar days of enrollment into CalOptima Health or for members less than 18 months of age within periodicity timelines established by AAP Bright Futures
Non-Urgent Appointments for Primary Care	Within 10 business days of request
Non-Urgent Appointments with Specialist Physicians	Within 15 business days of request
Non-Urgent Appointment with a Non-Physician Mental Health provider	Within 10 business days of request

Type of Care	Standard
Non-Urgent Appointments for Ancillary Services	Within 15 business days of request

Telephone Access Standards:

Description	Standard
Telephone Triage or Screening Services	Telephone triage or screening will be available 24/7. Telephone triage or screening waiting time will not exceed 30 minutes
Telephone Access After/During Business Hours for Emergencies	The phone message and/or live person must instruct members: • The length of wait time for a return call from the provider, and • How the caller may obtain urgent or emergency care
After-Hours Access	A PCP or designee will be available 24/7 to respond to after-hours member calls or to a hospital emergency room practitioner

Cultural and Linguistic Standards:

Description	Standard
Oral Interpretation	Oral interpretation, including, but not limited to, sign language, will be made available to members at key points of contact through an interpreter, either in person (upon request) or by telephone, 24/7
Written Translation	All written materials to members will be available in all threshold languages as determined by CalOptima Health in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services
Alternative Forms of Communication	Informational and educational information for members in alternative formats will be available upon request or standing request at no cost in all threshold languages in at least 20-point font, audio format or braille, or as needed within 21 business days of request or within a timely manner for the format requested

Description	Standard
Telecommunications Device for the Deaf	Teletypewriter (TTY) and auxiliary aids shall be available to members with hearing, speech or sight impairments at no cost, 24/7. The TTY Line is **711**
Cultural Sensitivity	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
Moral Objection	In the event a provider has a religious moral or ethical objection to perform or otherwise support the provision of covered services, CalOptima Health or health network must arrange on a timely basis for, coordinate and ensure members receive covered services through referrals to a provider that has no religious or ethical objection to performing the requested service or procedure at, no additional expense to DHCS or member.

Other Access Standards:

Description	Standard
Physical Accessibility	Provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.
Rescheduling Appointments	Appointments will be promptly rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care is consistent with good professional practice
Minor Consent Services	Covered services of a sensitive nature which minors do not need parental consent to access.
Family Planning Services	Members shall have access to family planning services and sexually transmitted disease services from a provider of member's choice without referral or prior authorization, either in or out-of-network.

Moral or Ethical Objection: In the event a provider has a moral or ethical objection to providing a covered service to a member, CalOptima Health or a health network shall refer the member to a different provider at no extra cost to CalOptima Health.

CalOptima Health Policies and Procedures:

GG.1118: Family Planning Services, Out-of-Network

GG.1508: Authorization and Processing of Referrals

GG.1600: Access and Availability

DD.2002: Cultural and Linguistic Services

This section applies to the following CalOptima Health programs:

OneCare

ACCESS STANDARDS

OneCare is required to adhere to patient care access and availability standards as required by DHCS and CMS. DHCS and CMS implemented these standards to ensure that OneCare members can get an appointment for care on a timely basis, reach the provider over the phone and access interpreter services as needed.

Contracted physicians and health networks are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards. OneCare monitors their health networks and providers for compliance. OneCare may develop a corrective action plan for providers and health networks that do not meet these standards. Please refer to CalOptima Health Policy MA.7007: Access and Availability Standards for more information related to CalOptima Health's monitoring process.

UNDERSTANDING THE ACCESS STANDARDS

Please see below for a brief description of the access standards for OneCare members:

Primary Care and Behavioral Health Services Standards:

Type of Care	Standard
Emergency Services	Immediately
Urgent Care Services	Immediately
Services Not Emergent or Urgently Needed but Requires Medical Attention	Within 7 business days
Routine and Preventive Care	Within 30 business days

Cultural and Linguistic Standards:

Description	Standard
Oral Interpretation	Oral interpretation, including, but not limited to, sign language, will be made available to members at key points of contact through an interpreter, either in person (upon request) or by telephone, 24/7.
Written Translation	All written materials to members will be available in all threshold languages as determined by CalOptima Health in accordance with CalOptima Health policy MA.4002: Cultural and Linguistic Services

Description	Standard
Alternative Forms of Communication	Informational and educational information for members in alternative formats will be available at no cost in all threshold languages upon request in at least 20-point font, audio format or braille, or as needed within 21 business days of request or within a timely manner for the format requested
Telecommunications Device for the Deaf	Teletypewriter (TTY) and auxiliary aids will be available to members with hearing, speech or sight impairments at no cost, 24/7. The TTY line is **711**
Cultural Sensitivity	Practitioners and staff will 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

Other Access Standards:

Specialist Care	Members shall have access to necessary specialist care, and in particular female members are given the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

Moral or Ethical Objection: In the event a provider has a moral or ethical objection to providing a covered service to a member, CalOptima Health or a health network shall refer the member to a different provider at no extra cost to CalOptima Health.

CalOptima Health Policies and Procedures:

GG.1118: Family Planning Services, Out-of-Network

GG.1508: Authorization and Processing of Referrals

MA. 7007: Access and Availability and Availability Standards

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

M7: REPORTING POTENTIAL QUALITY OF CARE ISSUES

CalOptima Health monitors the quality of care provided to members by its health networks and providers. As a part of this monitoring effort, CalOptima Health 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 on these investigations, CalOptima Health 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:

- 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 mental or physical health
    b. Unnecessary prolonged treatment, complications or readmission
    c. Failure to provide appropriate treatment that 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 Health staff may each report potential quality of care issues.

HOW TO REPORT A POTENTIAL QUALITY OF CARE ISSUE

- The quality of care issue should be directed to:

  CalOptima Health
  Attention: Quality Improvement Department
  505 City Parkway West
  Orange, CA 92868

  Or qualityofcare@caloptima.org

  Or fax to **657-900-1615**

  Please include the member's name, CIN, provider's full name and address, and a description of the issue or concern, including the dates the incident occurred.

- **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 Health will request that the health network gather documents, which may include medical records and the provider's respond to the complaint. CalOptima Health shall conduct a case review of the information received and evaluate the issue.

b. **CCN and COD** — If the case involves a CCN or COD member, CalOptima Health will request documents, which may include medical records and a response, from the rendering provider. CalOptima Health shall conduct a case review of the requested information and evaluate the issue.

CalOptima Health's physician reviewer will determine if a quality-of-care issue has occurred. If a quality issue exists, CalOptima Health's Credentialing and Peer Review Subcommittee may request corrective action or recommend de-credentialing and 805 reporting to the appropriate state board which may lead to termination of the contract.

- **Will the Provider or Party Filing the Complaint Hear About Resolution?**
  The reporting party 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 Health's Provider Resource Line at **714-246-8600**.

CalOptima Health Policies and Procedures:

GG.1611: Potential Quality Issue Review Process

GG.1615: Corrective Action for Practitioners

This section applies to the following CalOptima Health programs:

Medi-Cal

N1: ASSISTANCE FROM CALOPTIMA HEALTH CUSTOMER SERVICE

CalOptima Health's Customer Service department responds to the questions and needs of members, as well as questions from providers about their members. Customer Service also works closely with community agencies and organizations to coordinate care for CalOptima Health members.

Customer Service supports CalOptima Health's providers by helping members to:

1. Choose or change a PCP
2. Know how to access care within the managed care system
3. Understand their benefits and how to access care
4. Communicate and work with their doctors
5. Recognize their rights and responsibilities as members

Customer Service provides the following services, which assist both members and providers:

1. **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 and Farsi. The call center staff assists daily walk-in members and provides coverage of the reception area.

2. **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.

3. **Cultural and Linguistic Services:** Customer Service provides and facilitates interpretation and translation services. Interpreter services are necessary to assist many CalOptima Health members in communicating with their health care providers. Translation services are available in CalOptima Health's threshold languages. Cultural and linguistic services also facilitate and provide training and cultural events to promote organization-wide cultural competency.

4. **Member Communications:** Customer Service develops, produces and distributes Customer Service member communications and notifications for all CalOptima Health programs.

5. **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 PCP occurring with a health network change.

HOW TO CONTACT CALOPTIMA HEALTH'S CUSTOMER SERVICE DEPARTMENT FOR ASSISTANCE

CalOptima Health's Customer Service department can help providers with questions about CalOptima Health members. To reach Customer Service, call **714-246-8600**, Monday through Friday, from 8 a.m. to 5:30 p.m.

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

N1: ASSISTANCE FROM CALOPTIMA HEALTH CUSTOMER SERVICE

OneCare (HMO D-SNP) Customer Service responds to the questions and needs of OneCare members, as well as questions from providers about their members. OneCare Customer Service also works closely with community agencies and organizations to coordinate care for OneCare members. Phone lines are staffed in the required threshold languages: English, Spanish and Vietnamese. OneCare Customer Service staff also assist daily walk-in members.

OneCare Customer Service supports OneCare's providers by helping members to:

- Choose or change a primary care provider (PCP) or health network.
- Know how to navigate 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.
- Connect members to CalOptima Health Behavioral Health for mental health care.

OneCare Customer Service provides the following services, which assist both members and providers:

- Handles incoming member and provider calls regarding eligibility
- Helps facilitate services for OneCare members including prior authorization status, coordination of care, and other issues or inquiries
- Educates members about services and benefits
- Assists members with scheduling health care appointments
- Assists members in obtaining prescriptions
- Connects members with resources in the community
- Advocates for OneCare members

Members can call OneCare Customer Service 24 hours a day, 7 days a week, or visit our office Monday through Friday, from 8 a.m. to 5 p.m. Providers and members can speak with OneCare Customer Service by calling our toll-free number at **877-412-2734** (TTY 711). For more information, visit www.caloptima.org/onecare

Mental Health Services

CalOptima Health covers the following mental health services:

- Outpatient mental health services
- Individual and group mental health testing and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include lab work, drugs and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Inpatient mental health services*
- Partial hospitalization/intensive outpatient programs*

*Authorization rules may apply.

For more information on mental health services covered by CalOptima Health, call CalOptima Health's Behavioral Health Line at **855-877-3885** (TTY **711**).

Cultural and Linguistic Services
Cultural and Linguistic Services provides and facilitates interpretation and translation services. Interpreter services are necessary to assist many OneCare members in communicating with their health care providers. Translation services are available in OneCare's threshold languages. Cultural and Linguistic Services also facilitates and provides training and cultural events to promote organization-wide cultural competency.

Communications
Member Communications develops, produces and distributes Customer Service member communications and notifications for all CalOptima Health programs.

Data Management
Data Management maintains the integrity of member eligibility data through the daily reconciliation of reports and manual correction of data fallout. Additionally, Data Management administers the data on member selections and changes of a medical group, as well as data on any selections and changes of a PCP occurring with a medical group change.

This section applies to the following CalOptima Health programs:

Medi-Cal

N2: MEMBER LIAISON PROGRAM FOR SENIORS AND PERSONS WITH DISABILITIES (SPD)

The Member Liaison Program is dedicated to helping CalOptima Health seniors, members with disabilities or chronic conditions, members without housing and members under the age of 21 who participate in the Whole-Child Model program 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 Health members through the health care system. They help members obtain proper care, receive 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 Health programs as well as accessing benefits and services through our contracted providers.

The member liaison specialists can assist your CalOptima Health members by:

1. Scheduling appointments with a doctor
2. Arranging for non-emergency medical transportation
3. Confirming the status of their Durable Medical Equipment including wheelchairs, wheelchair repairs, crutches and other supplies
4. Forwarding CalAIM Enhanced Care Management and/or Community Supports services referrals

HOW TO REFER MEMBERS TO THE MEMBER LIAISON PROGRAM

If you have a patient who may benefit from the 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 Health'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 SPD:

Eligible Member	Aid Code
Aged	10, 14, 16, 1E, 1H, 1X
Blind/Disabled	20, 24, 26, 2E, 2H, 36, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, 60, 64, 66, L6
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W
Long-Term Care	13,23,53,63

For training and additional resources regarding SPD, visit the Providers section of the CalOptima Health website.

This section applies to the following CalOptima Health programs:

Medi-Cal

N3: HEALTH NETWORK AND PRIMARY CARE PROVIDER (PCP) SELECTION

CalOptima Health is committed to ensuring that its health network-eligible members have ample opportunity to select a primary care provider (PCP) and health network, both when they join CalOptima Health and on an ongoing basis.

WHAT PROVIDERS SHOULD KNOW ABOUT THE SELECTION PROCESS

Most CalOptima Health members are eligible to enroll in a health network. For more information regarding eligible members, see Section **B1: CalOptima Health Department and Program Contact Information.** The following outlines the major elements of the selection process for members who are eligible to enroll in a health network.

Choice Upon Initial Enrollment Into CalOptima Health

1. New members to CalOptima Health have the opportunity to select a PCP and a health network upon enrollment.

2. New members receive an enrollment packet containing a Health Network Selection form and a Health Network and Provider Directory, which list CalOptima Health's health networks, PCPs and hospitals.

3. Members must complete the Health Network Selection form indicating their choice of health network and PCP, and return it to CalOptima Health.

4. If CalOptima Health receives a member's completed Health Network Selection form by the 10th calendar day of a month, the member will be enrolled in his or her selected health network on the first calendar day of the following month.

5. If CalOptima Health receives a member's completed Health Network Selection form after the 10th calendar day of a month, the member will be enrolled in his or her selected health network on the first calendar day of the month after the immediately following month.

6. If a member does not choose a health network, CalOptima Health will auto-assign the member to a health network based on a predetermined algorithm.

7. A health network-eligible member may change his or her health network for any reason every 30 days.

PCP Selection/Changes

1. Members may choose any of the doctors listed in the CalOptima Health Network and Provider Directory as their PCP. If the PCP is not open to new members, the health network will ask the member to choose another PCP.

2. Members may change their PCP through their health network every 30 days.

3. Members may request to change their PCP by contacting their health network.

Some CalOptima Health members are enrolled in CalOptima Health Direct on a permanent basis and are not eligible to join a health network because they meet certain eligibility criteria. In general, these members may seek services from Medi-Cal providers accepting CalOptima Health payment.

If you have questions or need more information about CalOptima Health's provider and health network selection process, call CalOptima Health's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

CalOptima Health Policies and Procedures:

DD.2008: Health Network Selection

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP) D-SNP), a Medicare Medi-Cal Plan

N3: HEALTH NETWORK AND PRIMARY CARE PROVIDER (PCP) SELECTION

OneCare (HMO D-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 D-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 accessing or requesting a Provider Directory.
    b. Members may choose any of the doctors listed in the OneCare (HMO D-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 Health Policies and Procedures:

MA.4010: Physician Group and PCP Selection and Assignment

This section applies to the following CalOptima Health programs:

Medi-Cal

N4: MEMBER RIGHTS AND RESPONSIBILITIES

CalOptima Health is required to inform its members of their rights and responsibilities and ensure that members' rights and responsibilities are respected and observed. CalOptima Health provides this information to members in the Member Handbook upon enrollment, annually in the member newsletter, on CalOptima Health'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 Health members have the right to:

1. Be treated with respect and dignity by all CalOptima Health and provider staff.
2. Privacy and to have medical information kept confidential.
3. Get information about CalOptima Health, our providers, the services they provide and their member rights and responsibilities.
4. Choose a doctor within CalOptima Health's network unless the doctor is unavailable or is not accepting new patients.
5. To change Medi-Cal managed care plans upon request, if applicable.
6. Talk openly with health care providers about medically necessary treatment options, regardless of cost or benefit.
7. Help make decisions about their health care, including the right to say "no" to medical treatment.
8. Voice complaints or appeals, either verbally or in writing at any time, about CalOptima Health or the care we provide. There is no time limit to file a complaint. CalOptima Health can assist with filing a complaint or grievance.
9. Submit grievances, either verbally or in writing, about CalOptima Health, providers, care received and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
10. To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.
11. Receive fully translated written information including grievances and appeals notices.
12. Get oral interpretation services in the language that they understand at no cost.
13. Make an advance directive including an explanation as to what an advance directive is.

14. To have access to FQHCs, RHCs and HIS programs outside of CalOptima Health's network, pursuant to federal law.

15. Ask for a State Fair Hearing, including information on the conditions under which a State Fair Hearing can be expedited. CalOptima Health can assist with filing for a State Fair Hearing.

16. Have access to their medical record and, where legally appropriate, get copies of, update or correct their medical record.

17. Access minor consent services.

18. Receive written member informing materials in alternative formats, including braille, large-size print no smaller than 20-point font, accessible electronic format, and audio format upon request and in accordance with 45 CFR sections 84.52(d), 92.202, and 438.10.

19. Have timely access to network providers.

20. Be free from any form of control, restraint, seclusion or limitation used as a means of coercion, discipline, pressure, punishment, convenience or retaliation.

21. Know the medical reason for CalOptima Health's decision to deny, delay, terminate or change a request for medical care.

22. To ask for an appeal of a decision to deny, defer, or limit services or benefits.

23. Obtain free legal help at a local aid office or other groups.

24. Get information about their medical condition and treatment plan options in a way that is easy to understand.

25. Make suggestions to CalOptima Health about their member rights and responsibilities.

26. Freely exercise these rights without retaliation or any adverse conduct by CalOptima Health and/or CalOptima Health affiliates, including subcontractors, downstream subcontractors, network providers or the state.

CalOptima Health 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 Health 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 HEALTH'S MEMBER RIGHTS AND RESPONSIBILITIES

CalOptima Health's Customer Service department can help providers with questions about CalOptima Health's PCP and health network selection process. To reach Customer Service, call **714-246-8600**, Monday through Friday, from 8 a.m. to 5:30 p.m.

CalOptima Health Policies and Procedures:

DD.2001: Member Rights and Responsibilities

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

N4: MEMBER RIGHTS AND RESPONSIBILITIES

OneCare (HMO D-SNP) is required to inform its members of their rights and responsibilities and ensure that members' rights and responsibilities are respected and observed. OneCare provides this information to members annually in the Evidence of Coverage (EOC) and upon request.

CalOptima Health members have the right to:

- Be treated with respect and dignity by all CalOptima Health and provider staff.
- Privacy and to have medical information kept confidential.
- Get information about CalOptima Health, our providers, the services they provide and their member rights and responsibilities.
- Choose a doctor within CalOptima Health's network unless doctor is unavailable or is not accepting new patients.
- Change Health Plans upon request.
- Talk openly with health care providers about medically necessary treatment options, regardless of cost or benefit.
- Help make decisions about their health care, including the right to say "no" to medical treatment.
- Voice complaints or appeals, either verbally or in writing at any time, about CalOptima Health or the care we provide. There is no time limit to file a complaint. CalOptima Health can assist with filing a complaint or grievance.
- Submit Grievances, either verbally or in writing, about CalOptima Health, providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
- To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.
- Receive fully translated written information including grievances and appeals notices.
- Get oral interpretation services in the language that they understand at no-cost.
- Make an advance directive including an explanation as to what an Advance Directive is.
- Access family planning services such as Freestanding Birth Centers and midwifery services, Federally Qualified Health Centers, Indian Health Service Facilities, Rural Health Clinics, sexually transmitted disease services and emergency services outside CalOptima Health's network.

- Ask for a state fair hearing, including information on the conditions under which a state fair hearing can be expedited. CalOptima Health can assist with filing for a State Fair Hearing.
- Have access to their medical record and, where legally appropriate, get copies of, update or correct their medical record.
- Access minor consent services.
- Receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format upon request and in accordance with 45 CFR sections 84.52(d), 92.202, and 438.10.
- Have timely access to network providers.
- Be free from any form of control, restraint, seclusion or limitation used as a means of coercion, discipline, pressure, punishment, convenience or retaliation.
- Know the medical reason for CalOptima Health's decision to deny, delay, or terminate or change a request for medical care.
- To ask for an appeal of decision to deny, defer or limit services or benefit.
- Obtain free legal help at local aid office or other groups.
- Get information about their medical condition and treatment plan options in a way that is easy to understand.
- Make suggestions to CalOptima Health about their member rights and responsibilities.
- Freely exercise these rights without retaliation or any adverse conduct by CalOptima Health and/or CalOptima Health affiliates including Subcontractors, Downstream Subcontractors, Network Providers or the state.

CalOptima Health members are responsible for:

- Knowing, understanding and following their member handbook.
- Understanding their medical needs and working with their health care providers to create their treatment plan.
- Following the treatment plan they agreed to with their health care providers.
- Telling CalOptima Health and their health care providers what we need to know about their medical condition so we can provide care.
- Making and keeping medical appointments and telling the office when they must cancel an appointment.
- Learning about their medical condition and what keeps them healthy.

- Taking part in health care programs that keep them healthy.
- Working with and being polite to the people who are partners in their health care.

HOW TO OBTAIN MORE INFORMATION ABOUT CALOPTIMA HEALTH'S MEMBER RIGHTS AND RESPONSIBILITIES

CalOptima Health's Customer Service department can help providers with questions about CalOptima Health'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. Providers can also visit the Members section of the CalOptima Health website www.caloptima.org/onecare

CalOptima Health Policies and Procedures:

MA.4001: Member Rights and Responsibilities

This section applies to the following CalOptima Health programs:

Medi-Cal

N5: NEW MEMBER WELCOME MATERIALS

All CalOptima Health members receive an initial mailing when they first become a CalOptima Health member. Health network-eligible members receive Packet 1 or Packet 4 (see information below). The packet contents may vary depending on whether a member is eligible for a health network, CalOptima Health Direct (COHD)-Administrative Medi-Cal/Medicare, or CalOptima Health Community Network (CHCN), as described in the packets below.

In the Packet 1 and Packet 4 mailings, 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 who do not have an SPD aid code within seven calendar days of the member becoming eligible with CalOptima Health.

Contents include:

- New Member Welcome Letter/CalOptima Health Medi-Cal ID Card
- Medi-Cal Summary of Benefits
- Health Network Selection Form
- Business Reply Envelope
- Health Network Selection Form Guide
- Health Network New Member Orientation Invitation
- Healthy You Initial Health Appointment
- Notice of Nondiscrimination/Language Assistance Taglines
- Health Information Form
- Instructions on how to access the Provider Directory and Member Handbook

PACKET 2: CALOPTIMA HEALTH DIRECT-ADMINISTRATIVE MEDI-CAL AND MEDICARE (MEDI-MEDI) NEW MEMBER WELCOME PACKET

Packet 2 contents are sent to COHD-Administrative Medi-Medi members within seven calendar days of member becoming eligible with CalOptima Health.

Contents include:

- COHD Welcome Letter
- CalOptima Health Medi-Cal ID Card
- COHD New Member Orientation Invitation
- Notice of Nondiscrimination/Language Assistance Taglines
- Healthy You Initial Health Appointment
- Health Information Form
- Instructions on how to access the Provider Directory and Member Handbook

PACKET 3: CALOPTIMA HEALTH DIRECT-ADMINISTRATIVE NEW MEMBER WELCOME PACKET

Packet 3 contents are sent to CalOptima Health Direct-Administrative members within seven calendar days of member becoming eligible with CalOptima Health.

Contents include:

- COHD Welcome Letter
- CalOptima Health Medi-Cal ID Card
- COHD New Member Orientation Invitation
- Notice of Nondiscrimination/ Language Assistance Taglines
- Health Information Form
- Instructions on how to access the Provider Directory and Member Handbook

PACKET 4: HEALTH NETWORK NEW MEMBER WELCOME PACKET — SPD

Packet 4 contents are sent to health network-eligible members with an SPD aid code within seven calendar days of the member becoming eligible with CalOptima Health.

Contents include:

- New Member Welcome Letter/CalOptima Health Medi-Cal ID Card
- Medi-Cal Summary of Benefits
- Health Network Selection Form
- Business Reply Envelope
- Health Network Selection Form Guide
- Health Network New Member Orientation Invitation
- Healthy You Initial Health Appointment
- Notice of Nondiscrimination/Language Assistance Taglines
- Health Information Form
- Provider Directory
- Instructions on how to access the Member Handbook

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

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. Member Handbook Insert
2. Summary of Benefits
3. Acknowledgement of Completed Enrollment Letter
4. OneCare ID Card
5. Notice of Privacy Practices
6. Notice of Nondiscrimination
7. Multi-Language Insert
8. Provider Directory and Formulary Insert

PACKET 50A: ONECARE WELCOME SUBSEQUENT PACKET

1. New Member Orientation Invitation
2. Silver & Fit Welcome Letter and Brochure

PACKET 51: 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 Health's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m.
to 5 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

N6: OBTAINING ACCESS TO CULTURAL AND LINGUISTIC SERVICES

State and federal regulations require CalOptima Health to make interpreter and translation services for limited English proficient (LEP) members available. CalOptima Health is also required to facilitate, promote and provide training in cultural competency for its staff, as well as for health network staff and CalOptima Health providers.

CalOptima Health'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 Health'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 Health will contact, in advance, provider offices selected by the DHCS to participate in its cultural and linguistic services audit.

OBTAINING MORE INFORMATION ABOUT CALOPTIMA HEALTH'S CULTURAL AND LINGUISTIC SERVICES

To register for CalOptima Health's Awareness and Education Seminars, contact Cultural and Linguistic Services via email at: culturallinguistic@caloptima.org.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

N7: ACCESSING INTERPRETER SERVICES

Federal and state regulations require CalOptima Health 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 Health 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 Health 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 Health 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 24/7.
    b. Face-to-face interpreter service, including sign language, is recommended when a 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 COD, call CalOptima Health'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.

HEALTH NETWORK INTERPRETER SERVICES CONTACT LIST

Health Network	Telephonic Interpreter Service Contact	Face-to-face Interpreter Service Contact
Alta Med Health Services	877-462-2582	877-462-2582
AMVI Care Health Network	866-796-4245	866-796-4245
CHOC Health Alliance	800-424-2462 (Member line) 800-387-1103 (Provider line)	800-424-2462 (Member line) 800-387-1103 (Provider line)
Family Choice Health Network	Language Line: 800-874-9426	800-611-0111
Noble Mid-Orange County	888-880-8811	888-880-8811 Ask for Utilization Department
Optum	888-656-7523	888-656-7523
Prospect Medical Group	800-708-3230	800-708-3230 or fax request to 714-560-7305 Or submit a request online: www.prospectmedical.com
Regal Medical Group	844-292-5173	844-292-5173
United Care Medical Network	877-225-6784	877-225-6784

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

N8: TIPS FOR DOCUMENTING INTERPRETER SERVICES

Federal and state regulations require that CalOptima Health, its health networks, medical groups and providers offer free interpreter services to limited English proficient members. Regulations also require CalOptima Health 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 Health's Language Assistance program.

TIPS FOR DOCUMENTING INTERPRETER SERVICES

1. CalOptima Health 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.)*

*Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; www.iceforhealth.org/.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal 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.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

N10: TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT (LEP) MEMBERS

Regulations require that CalOptima Health, 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?"

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

N11: CULTURAL COMPETENCY TRAINING

CalOptima Health 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 Health's member population.

2. Provide tips and resources to help enhance services provided to CalOptima Health members.

3. Comply with regulatory mandates.

CalOptima Health 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 Health's Awareness and Education Seminars, contact Cultural and Linguistic Services via email at: culturallinguistic@caloptima.org.

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

O1: REFERRALS FOR HEALTH AND WELLNESS SERVICES

Health and wellness services are provided in all threshold languages at no cost by CalOptima Health Population Health Management (PHM). All eligible CalOptima Health members are offered these benefits in person, telephonically or in a group session. The goal is to assist and support the work of providers in promoting patient self-management and healthy behaviors while meeting established guidelines.

CalOptima Health's health and wellness topics include, but are not limited to:

- Asthma
- Cholesterol
- Chronic kidney disease
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Depression
- Fitness or exercise
- Heart disease
- High blood pressure
- Injury prevention
- Preventive screenings
- Nutrition
- Pregnancy
- Tobacco cessation
- Weight control

CalOptima Health's Bright Steps program manages members who are pregnant and up to 12 months post-delivery. Members can receive services such as health coaching, nutrition education and assistance with resources. Pregnant members can self-refer into the program by calling **1-888-587-8088,** or providers can submit a Pregnancy Notification Report (PNR) found at www.caloptima.org/forProviders/Resources/Commonforms to CalOptima Health at any point during pregnancy.

Members diagnosed with diabetes, asthma, congestive heart failure or chronic kidney disease are enrolled in the CalOptima Health Chronic Care Program. Newly identified members receive an introductory letter informing them of their eligibility to participate in the program, how to use program services, and instructions on how to opt out if they so choose.

CalOptima Health stratifies Chronic Care Program members into risk categories based on the severity of their condition and utilization characteristics. Based on their risk level, the member may receive educational mailings and/or be assigned to a health coach for telephonic outreach. The health coach makes outreach calls to members and performs a comprehensive assessment, including a discussion regarding the importance of medication adherence. Based on the assessment, the health coach collaborates with the member and their provider to develop a self-management Individualized Care Plan (ICP). In addition, each member receives an educational mailing package on condition-specific information.

REFERRING MEMBERS AND MEMBER OPT-OUT OPTION:

Providers can help identify members who would likely benefit from receiving health and wellness services. In addition to pregnancy and chronic conditions, members can receive assistance with general health and wellness topics such as high cholesterol, hypertension, nutrition, physical activity, tobacco cessation and more.

- To refer a non-pregnant member, providers should complete a Health and Wellness Referral Form found at www.caloptima.org/forProviders/Resources/Commonforms and fax it to **714-338-3127**.

- Members can self-refer to any health and wellness service or program by calling customer service at **1-888-587-8088 (TTY 711)**, Monday through Friday from 8 a.m. to 5 p.m.

- **Opting out of health and wellness services**: Some identified members may receive health education materials about their chronic conditions. If a member would like to opt out of the program, they must call customer service as indicated above.

HOW TO GET MORE INFORMATION ABOUT HEALTH AND WELLNESS SERVICES

For more information about CalOptima Health's health and wellness services:

- Call CalOptima Health's Customer Service department at **1-888-587-8088 (TTY 711)**
- Email PHM at healthpromotions@caloptima.org
- Visit CalOptima Health's website at www.caloptima.org/healthandwellness

CalOptima Health Policies and Procedures:

GG.1201: Health Education Programs

This section applies to the following CalOptima Health programs:

Medi-Cal

O2: BASIC POPULATION HEALTH MANAGEMENT

As defined by DHCS, Basic Population Health Management (BPHM) is an approach to care that ensures all members have access to needed programs and services, at the right time and in the right setting, regardless of the member's risk tier.

The CalAIM: Population Health Management Policy Guide further details BPHM to ensure all CalOptima Health members receive BPHM services regardless of their level of need. The comprehensive package of BPHM services and supports includes:

- Primary care
- Care coordination
- Navigation and referrals across health and social services
- Services provided by CHWs
- Wellness and prevention programs
- Chronic disease programs
- Programs to improve maternal health outcomes
- Case management services for children under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

BPHM services promote health equity and will align with National Standards for Culturally and Linguistically Appropriate Services (CLAS) to ensure the provision of BPHM services to each member is made in a culturally and linguistically appropriate manner that responds to the member's needs, beliefs and preferences.

BPHM services include integrating CHWs to assist members with PCP engagement, connection to services that address social determinants of health (SDOH), wellness promotion and prevention, assistance with managing chronic disease, as well as support efforts to improve maternal and child health.

BPHM services will support efforts to improve maternal health outcomes which align with the DHCS Comprehensive Quality Strategy's Bold Goals. A particular focus within this area is to prioritize the reduction of health disparities, particularly for Black, Native American and Pacific Islander persons, by addressing systemic discrimination in maternity care and providing culturally competent birth and postpartum care through doula services.

CalOptima Health, contracted providers and delegated networks must ensure that each member has access to and is utilizing needed health and health-related social services through processes that monitor and increase PCP engagement, develop strategies to address utilization patterns, and ensure non-duplication of services.

HOW TO GET MORE INFORMATION ABOUT BASIC POPULATION HEALTH MANAGEMENT

For more information about CalOptima Health's Basic Population Health Management:

- Call CalOptima Health's PHM department at **1-888-587-8088**
- Email PHM at healthpromotions@caloptima.org
- Visit DHCS's website at https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx

CalOptima Health Policies and Procedures:

GG.1667: CalAIM Population Health Management Program

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare, PACE

P1: FRAUD, WASTE OR ABUSE — INVESTIGATING AND REPORTING

Federal and state regulations require CalOptima Health 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:

- A person using someone else's CalOptima Health card
- A member getting a bill for services covered by CalOptima Health
- A member getting a bill for unnecessary services or services not performed
- A provider submitting claims for duplicate services, unbundled services or up-coded services
- 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

FALSE CLAIMS ACT

The Federal False Claims Act (FCA) identifies several actions that constitute violations of the FCA including, but not limited to:

- Knowingly presenting or causing to be presented a false or fraudulent claim for payment with U.S. government funds
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim to the government
- Knowingly making, using or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property owed the government
- Conspiring to commit a violation of the above

The Federal FCA protects employees and contractors who report a violation from discrimination, harassment, suspension or termination of employment as a result of the report. Employees, contractors and agents who are retaliated against in their employment (e.g. termination, demotion, suspension or other acts of discrimination) for lawful actions related to the filing of FCA actions or other efforts to prevent Federal FCA violations are entitled to all relief necessary to be made whole.

HOW TO REPORT SUSPECTED HEALTH CARE FRAUD

Suspected fraud or abuse should be reported to CalOptima Health immediately through the following means:

- 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 Health website.
- Email the form and supporting documents to fraud@caloptima.org or fax the form and all supporting documents to CalOptima Health's Office of Compliance at **714-481-6457.**
- Contact the Compliance and Ethics Hotline at **1-855-507-1805.** You may remain anonymous when calling the hotline.
- Information submitted via mail to:

  CalOptima Health SIU
  505 City Parkway West
  Orange, CA 92868

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 Health in accordance with the terms and conditions of its contract and policy HH.1105: Fraud, Waste and Abuse Detection and HH.1107: Fraud, Waste and Abuse Investigation and Reporting.

CalOptima Health's 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 Health may coordinate an independent internal investigation with other CalOptima Health departments and FDRs, health networks or any other delegated entity, including procuring the services of contracted investigators, as needed.

CalOptima Health will report, as appropriate, to all local, state and federal entities.

MONTHLY AND ANNUAL REQUIREMENTS

Federal and state regulations require CalOptima Health 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 Health monies:

- The General Services Administration's (GSA) System for Award Management (SAM) website
- The Office of Inspector General Exclusions Database (http://exclusions.oig.hhs.gov/)
- Medicare Exclusion Database (MED)
- Medi-Cal's Suspended and Ineligible (S&I) list
- The Social Security Administration Death Master File (SSADMF)

CalOptima Health 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, training and reference materials, organizations can refer to the OIG's website at http://oig.hhs.gov.

CalOptima Health requires an FDR, health network or any other delegated entity to train all their employees, board Compliance Training members, contractors and sub-contracted entities on the following, annually:

- Fraud, Waste and Abuse (FWA) Training
    a. Upon completion of the FWA training, CalOptima Health requires FDRs, health networks or any other delegated entity to sign an Attestation for FWA Training.

CalOptima Health Policies and Procedures:

HH.1105: Fraud, Waste and Abuse Detection

HH.1107: Fraud, Waste and Abuse Investigation and Reporting

HH.2021: Exclusion Monitoring

HH.2023: Compliance Training

HH: 5000: Provider Overpayment Recovery Investigation and Reporting

HH.5004: False Claims Act Education

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare, PACE

P2: ABOUT HIPAA PRIVACY

HIPAA is a federal law that requires CalOptima Health and its providers to protect the security and privacy of its members' 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 Health 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 Health 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 Health and providers must adhere. CalOptima Health's Notice of Privacy Practices outlines CalOptima Health members' privacy rights and CalOptima Health's responsibilities. To obtain a copy of CalOptima Health's Notice of Privacy Practices, please visit the CalOptima Health website. Providers should have their own Notice of Privacy Practices.

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 Health. The chart also identifies the specific CalOptima Health request or authorization form to assist the member. Providers should have their own request or authorization form for patient use.

To view a copy of the applicable form, please visit the CalOptima Health website at www.caloptima.org.

Member Right	CalOptima Health Request/Authorization Forms
Members can request access to or copies of their PHI, which can include claims reports, care management records or enrollment information that is considered part of CalOptima Health's Designated Record Set (DRS). For providers, patients have the right to access their health information maintained by the provider (e.g., medical records, billing records, clinical laboratory test results, medical images [such as X-rays], wellness and disease management program files, and clinical notes). More information can be found at 45 C.F.R. § 164.524.	Individual Request for Access to Protected Health Information

Member Right	CalOptima Health Request/Authorization Forms
Members can request CalOptima Health to change their PHI records. CalOptima Health does not have to agree to the request.	Member Request to Amend Protected Health Information
Members can request an accounting of how their PHI was disclosed by CalOptima Health.	Request for Accounting of Disclosures
Members can request that CalOptima Health communicate with them via different modes or send mail to a different address other than their home residence.	Restriction on Manner/Method of Confidential Communications Form
Members can request that CalOptima Health restrict the use or disclosure of their PHI. CalOptima Health does not have to agree to the request.	Request for Restriction on Use or Disclosure of Protected Health Information
Members must authorize CalOptima Health to use or disclose their PHI to another person or organization.	Authorization for Use or Disclosure of Protected Health Information
Members must authorize CalOptima Health to use or disclose their PHI to a family member or friend who is involved in the member's care.	Authorization for Use or Disclosure of Protected Health Information

Safeguarding PHI

Both CalOptima Health 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.

PHI	PHI in Paper Form
In the Office	PHI should be locked away during non-business hours. PHI should not be visible to others.
Fax	Staff must verify fax numbers and recipients prior to sending the fax. Outgoing faxes must include a fax cover sheet that contains a confidentiality statement. Incoming/outgoing faxes must not be left unattended during non-business hours.
Mail	Quality checks of mailings (i.e., verifying the address and contents) must be conducted prior to sending. Envelopes or packages must be properly sealed and secured prior to sending.

PHI	PHI in Paper Form
Handling PHI offsite	PHI must be protected during transport to and from the office using binders, folders or protective covers. PHI must not be left unattended in vehicles. PHI must not be left unattended in baggage at any time during travel.
Disposal	PHI must be shredded; never recycle anything containing PHI.

PHI	PHI in Electronic Form
Provider Portal	Do not share user login information with others in your office. Only access the minimum necessary information for treatment, payment or operational purposes to accomplish the task at hand. Accessing additional PHI that is not job-related is a violation of HIPAA. Do not upload incorrect patient information into the portal. Authorizations or any other PHI (i.e., claims information) must belong to the applicable patient.
Email	Do not include PHI, such as the individual's name or beneficiary ID number (CIN), in the subject line of emails. 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 email 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	PHI in Oral Form
Oral Communications	PHI must not be discussed in public areas.

PHI	PHI in Oral Form
	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 persons. 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 the 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 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 or persons via fax, email or 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. Accessing PHI that is not related to the job at hand.
5. Posting information about patients or pictures of patients on a social media website.
6. Unauthorized access of the provider's medical records or information systems by an unknown person.

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 Health member, whether caused by **CalOptima Health, a CalOptima Health network, a delegated entity or an FDR**, the provider should notify CalOptima Health **immediately** upon discovery. To report a breach to CalOptima Health, call **888-587-8088** and ask for the Privacy Officer, or email privacy@caloptima.org

CalOptima Health 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

This section applies to the following CalOptima Health programs:

Medi-Cal

Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The PCP plays a central role in structuring care for CalOptima Health members. The PCP is the main provider of health care services for CalOptima Health members. CalOptima Health's model of care is built around 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. Complete risk assessments, treatment planning, coordination of medically necessary services, referrals, follow-up and monitoring of appropriate services and resources required to meet the needs of the member.

3. 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, provide appropriate prescriptions as needed, and identify appropriate health education materials and interventions.

4. Ensure access to care 24/7, including accommodations for urgent care, procedures and hospitalizations.

5. Coordinate and direct appropriate care for members, including:
   a. IHA completed within 120 days of enrollment or PCP effective date (whichever is more recent) or documented within 12 months prior to enrollment/PCP effective date. The IHA includes a history of the member's physical and behavioral health, identification of risks, an assessment of the need for preventive screenings or services and health education, and the diagnosis and plan for treatment of any diseases.
   b. Member Risk Assessment
      i. New Pediatric Members — An assessment of at least one of the following risk assessment domains within 120 days of the effective date of enrollment of PCP effective date (whichever is more recent), or within 12 months prior to enrollment/PCP effective date.
      ii. SDOH: Documented assessments of SDOH in the progress notes or use of a validated screening tool.
      iii. Adverse Childhood Experiences (ACES): Documented use of validated screening tools such as the Pediatric ACEs and Related Life-Events Screener (PEARLS) for ages 0–19 or the ACE Questionnaire for ages 18 years and older.
   c. Pediatric Subsequent Risk Assessment — Completed annually (at each periodic well visit) or more frequently if any significant changes in health status are identified. An assessment of at least one of the above risk assessment domains (SDOH and ACEs) meets the standard.
   d. New Adult Members — An assessment of at least one of the following risk assessment domains within 120 days of the effective date of enrollment or PCP effective date (whichever is more recent) or within the 12 months prior to enrollment or PCP effective date.
      i. Health Risk Assessment
      ii. SDOH

iii. Cognitive Health Assessment (65 years and older)
    1. General Practitioner Assessment of Cognition (GPCOG)
    2. Mini-Cog
    3. Eight-item Informant Interview to Differentiate Aging and Dementia

e. Adult Subsequent Risk Assessment — Completed annually by the member or more frequently if any significant changes in health status are identified.
f. Preventive services in accordance with established standards and periodicity schedules as required by age and according to AAP and the USPSTF.
g. Referrals and authorizations to specialists, Durable Medical Equipment, home health, long-term care, etc.
h. Coordination and continuity of primary and specialty care, Durable Medical Equipment, home health, long-term care, hospitalizations, etc.

6. Documented follow-up and outreach to member who missed or canceled an appointment.

7. Record and document information in the member's medical record, including:
    a. Member office visits, emergency visits and hospital admissions
    b. Problem list, past medical history, past surgical history, psychosocial history, family history, allergies, medications, immunizations, surgeries, procedures and visits
    c. Communication log and member outreach
    d. Treatment, referral and consultation reports
    e. Lab and imaging studies

8. A physician must supervise any Schedule II drugs ordered by the physician assistant, as written in the Practice Agreement between the physician assistant and supervising physician or COHS.
    a. When Schedule II drugs are furnished by a NP, certified nurse practitioner (CNP) and/or CNM with Drug Enforcement Agency (DEA) supervision 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.

9. Communicate, orally and in writing, with the member in the member's preferred language, using available interpretation or translation services.

10. 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 Health Policies and Procedures:

GG.1110: Primary Care Practitioner Definition, Role and Responsibilities

GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) plays the central role in overseeing the care for CalOptima Health members. The PCP is the main provider of health care services for OneCare members. CalOptima Health model of care is built around 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. Complete risk assessments, treatment planning, coordination of medically necessary services, referrals, follow-up, and monitoring of appropriate services and resources required to meet the needs of the member.

3. 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, provide appropriate prescriptions as needed, and identify appropriate health education materials and interventions.

4. Ensure access to care 24/7, including accommodations for urgent care, procedures and hospitalizations.

5. Provide basic medical case management to assigned members:
    a. Ensure continuity of care for the member and foster an interactive relationship with 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 member's Interdisciplinary Care Team (ICT), which assesses the member's 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. Coordinate and direct appropriate care for members, including the review of the comprehensive Health Risk Assessment (HRA) that is completed within 90 calendar days after enrollment in OneCare, and schedule an appointment for high-risk members within 30 calendar days.

6. Coordinate and direct appropriate care for members, including:
    a. Health Risk Assessment (HRA), including comprehensive history and physical examination
    b. 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)
    c. Referrals and authorizations to specialists, Durable Medical Equipment, home health, long-term care, etc.
    d. Coordination and continuity of primary and specialty care, Durable Medical Equipment, home health, long-term care, hospitalizations, etc.

7. Follow-up and outreach to member who missed or canceled 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 list, past medical history, past surgical history, psychosocial history, family history, allergies, medications, immunizations, surgeries, procedures and visits
    c. Communication log and member outreach
    d. Treatment, referral and consultation reports
    e. Lab and imaging studies

9. A physician must supervise any Schedule II drugs ordered by the physician assistant, as written in the Practice Agreement between the physician assistant and supervising physician or County Organized Health Care System.
    a. When Schedule II drugs are furnished by a nurse practitioner (NP), certified nurse practitioner (CNP) and/or certified nurse-midwife (CNM) with a Drug Enforcement Agency (DEA) supervision 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.

10. Communicate, orally and in writing, with the member in the member's preferred language, using available interpretation or translation services.

11. 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 Health Policies and Procedures:

GG.1110: Primary Care Practitioner Definition, Role and Responsibilities

GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

Q2: MEMBER MEDICAL RECORD

CalOptima Health is responsible for ensuring that a complete medical record is maintained for each member that reflects all aspects of the member's care. CalOptima Health shall monitor a provider's compliance with maintaining a member's medical record during a medical record review. CalOptima Health shall maintain confidentiality of the member's medical information in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy, HIPAA security policies, and additional applicable state and federal laws. Upon request, providers shall provide access to a member 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 provider collects, processes, maintains, stores, retrieves, identifies and distributes clinical information.

Active Records

1. A provider shall label and file all active records in a defined system to facilitate the retrieval of a record on demand.
2. A provider shall store active records in a secured area that protects the records from loss, tampering, alteration or destruction.

Inactive Records

1. A provider may store inactive records in electronic or hard copy format in a secured area that protects the records from loss, tampering, alteration or destruction.
2. A provider shall maintain an inactive record through the following process:
    a. For an adult member, 10 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 10 years from the last date of service.
3. For OneCare 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

1. 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. Imaging studies
    c. Electroencephalograms (EEGs) and Echocardiograms (EKGs)
    d. Physical therapy, occupational therapy and speech therapy reports
    e. Home health and hospice reports
    f. Consultation reports
    g. Hospital records (admission/outpatient procedures)
    a. Emergency Department records

Member's Medical Record

1. CalOptima Health 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 name and additional identifiers such as date of birth or medical record number on each page
    b. Personal/biographical data in the record
    c. Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of a language interpreter and who provided the interpretation services
    d. All entries dated and author identified
    e. Problem list, past medical history, past surgical history, psychosocial history, family history, allergies, medications, immunizations, surgeries, procedures and visits
    f. Prominently noted allergies and adverse reactions
    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 of date, time, initials and action 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
    l. Documentation that Advance Directive information is offered.

2. A provider shall establish an individual record for each member and shall update the record during each visit or encounter.
3. The record shall be available in a legible, handwritten or typed format.
4. The record shall reflect the findings of each visit or encounter.
5. Addendums to records shall be clearly identified, signed and dated.

Authentication of Medical Record Entries

Every medical record entry 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, or, if signed electronically, with a date and time stamp.

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:

1. Date and time of missed appointment
2. All attempts to reach the member
3. 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

1. All member records shall be handled with strict confidentiality.
2. 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 Health Policy GG.1618: Member Request for Medical Records

and CalOptima Health HIPAA privacy policies.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements, according to CalOptima Health Policy HH.3000.

Monitoring and Evaluation

1. CalOptima Health shall evaluate the provider's compliance with these guidelines through the medical record review, as set forth in CalOptima Health 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 ensure member access to their medical records. Providers shall supply to other treating or consulting providers, at no cost to the member, a copy of the member's medical record under the following circumstances, including but not limited to:

1. If the record is necessary to facilitate the continuity of care
2. If the provider is transferring the member to another provider
3. 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 Health and its health networks shall sanction any provider who willfully withholds member medical records due to 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 according to CalOptima Health Policy GG.1618: Member Request for Medical Records.

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, according to CalOptima Health Policy GG.1618: Member Request for Medical Records.

For the purposes of utilization management, quality improvement and other CalOptima Health administrative processes, CalOptima Health 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 Health.

CalOptima Health Policies and Procedures:

GG.1603: Medical Records Maintenance

GG.1608: Full Scope Site Reviews

GG.1618: Member Request for Medical Records

MA.9201: Medical Records Maintenance

HH.3000: Notice of Privacy Practices

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

R1: PROVIDER COMPLAINT PROCESS

Medi-Cal and OneCare maintain a provider complaint process to review and resolve disputes for claims payments, appeals for utilization management decisions and grievances for all other non-payment-related issues.

There is one level in the CalOptima Health Community Network (CCN) and CalOptima Health Direct (COD) dispute process.

- Complaints involving claim payment decisions where CalOptima Health is at risk for payment must be submitted to CalOptima Health Grievance and Appeals Resolution Services (GARS) for review.

Complaints involving decisions made by CalOptima Health's Utilization Management (UM) department have two levels in the provider appeals process.

There are two levels in the health network provider complaint process:

- **Level 1** complaints involving disputes or appeals of UM decisions or claims payment decisions or actions taken by a CalOptima Health-contracted network or a third party administrator (TPA). Depending on the situation, Level 1 complaints are filed with either CalOptima Health-contracted networks or with the TPA.
- **Level 2** complaints are disputes or appeals of Level 1 decisions issued by a CalOptima Health-contracted network or a TPA.

Request for a Hearing
Providers who have received a complaint resolution letter from CalOptima Health, a CalOptima Health-contracted network or a TPA have the right to a hearing. A request for a hearing is limited to the following provider disputes:

- Recoupment of funds based upon audit findings of overpayments
- The imposition of sanctions or penalties
- Suspension or termination of the provider's participation in CalOptima Health, 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 on whether the provider filing the complaint is a Medi-Cal- or OneCare-contracted provider or a non-contracted provider.

FILING A PROVIDER COMPLAINT

If you have a contract with a Medi-Cal or OneCare health network or directly with CalOptima Health, follow the instructions under "Contracted Providers" below. If you do not have a contract with a Medi-Cal or OneCare health network or with CalOptima Health directly, follow the instructions under "Non-Contracted Providers."

Contracted Providers

- To file a complaint with CalOptima Health, please complete a Provider Dispute Resolution Request Form. To obtain a copy, visit the Providers section of the CalOptima Health website. Please see **Section R3: Required Documentation for Complaints** for tips on how to complete the form.
  - **If the complaint involves a payment or decision rendered by a CalOptima Health-contracted health network**, submit the Provider Dispute Resolution Request Form to the contracted network. For health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.
  - If the complaint involves a **payment or decision rendered by CalOptima Health directly**, submit the Provider Dispute Resolution Request Form to GARS. For more information on filing addresses, see **Section R4: Addresses for Filing Provider Complaints.**
- **Level 2** (applicable only for health networks other than CalOptima Health) — If you are not satisfied with the outcome of the CalOptima Health-contracted health network Level 1 complaint, you can file a Level 2 complaint with GARS. 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

- To file a complaint, complete a Provider Dispute Resolution Request Form. To obtain a copy, visit the Providers section of the CalOptima Health website. See **Section R3: Required Documentation for Complaints** for tips on how to complete the form.
- The payment dispute should be filed with the entity that issued the payment (or notice of non-payment).
  - If a CalOptima Health-contracted network issued the payment, file the complaint with the applicable network. For CalOptima Health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information.**
  - If the complaint involves payment from CalOptima Health, please fax the form to **714-954-2321** or submit it to:
    - CalOptima Health
      Grievance and Appeals Resolution Services
      505 City Parkway West
      Orange, CA 92868
  - If the complaint is not claims-related, submit the form to GARS. For information on where to submit the form, see **Section R4: Addresses for Filing Provider Complaints.**

- **Level 2 Payment Related** (applicable only for health networks other than CalOptima Health) — If you are not satisfied with the outcome of the Level 1 health network payment dispute, you can file a Level 2 payment dispute with GARS.
- **Payment Appeal** (OneCare**)** — You can file an appeal with GARS within 60 calendar days of the remittance advice. GARS 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, please visit the Providers section of the CalOptima Health website. If the decision is not wholly in your favor, GARS will forward your case file to the Medicare Independent Review Entity (IRE).
- **If you do not submit a signed waiver —** GARS will dismiss your appeal.
- **Maximus Federal Services (CMS-contracted IRE) —** GARS will automatically submit the Level 2 appeal to Maximus Federal Services if the appeal is not resolved wholly in favor of the non-contracted provider.

MEDI-CAL PROVIDER CLAIMS PROCESS: CLAIMS AND NON-CLAIMS ISSUES

Claims and Non-Claims Issues	Options Available to the Provider
Contracted/Non-contracted provider	If CalOptima Health is responsible for payment, file the payment dispute with GARS. File Level 1 Provider Dispute Resolution Request with the health network. File Level 2 Provider Dispute Resolution Request with GARS (applicable only for health networks other than CalOptima Health). Legal claims and judicial review may be available. See CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.

CalOptima Health Policies and Procedures:

HH.1101: Provider Complaint Process

ONECARE PROVIDER CLAIMS PROCESS: CLAIMS AND NON-CLAIMS ISSUES

Claims and Non-Claims Issues	Options Available to the Provider
Contracted provider	If CalOptima Health is responsible for payment, file the payment dispute with GARS. File Level 1 Provider Dispute Resolution Request with health network. File Level 2 Provider Dispute Resolution Request with GARS. Legal claims and judicial review may be available. See CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.

Claims and Non-Claims Issues	Options Available to the Provider
Non-contracted providers	**Underpayment Dispute** — The procedure that deals with the review of payment made with an amount deemed to be less than the amount that would be paid by Medicare. • If CalOptima Health is responsible for payment, file the payment dispute with GARS. File a Level 1 Provider Dispute Resolution Request with the health network that issues the payment. File a Level 2 Provider Dispute Resolution Request with CalOptima Health if you disagree with the health network's dispute decision. The health network or CalOptima Health will notify the provider of the decision. **Claim Appeal** — The procedure that deals with the review of an adverse decision (denial) made by CalOptima Health or a health network on services or the denial of payment for no authorization or no medical necessity. Additional appeal rights may include diagnosis related group (DRG) underpayment/payment denial, downcoding, bundling issues, level of care or rate of payment denials. • File Level 1 appeal with GARS. • Include a signed Waiver of Liability. If Waiver of Liability is not received within 60 calendar days from when the appeal was received, the appeal will be dismissed. Level 1 decision not wholly in favor of provider: • GARS forwards to Maximus Federal Services for external review. Level 2 decision not wholly in favor of provider: • File Level 3 appeal with an Administrative Law Judge Hearing. Level 3 decision not wholly in favor of provider: • File Level 4 appeal with the Medicare Appeals Council. Level 4 decision not wholly in favor of provider: • File Level 5 appeal with the Judicial Review.

CalOptima Health Policies and Procedures:

MA.9006: Provider Complaint Process

MA.9009: Non-Contracted Provider Payment Disputes

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

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 through the CalOptima Health Community Network (CHCN) or with one of OneCare's health networks follow CalOptima Health's 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, as 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 in Table 1.

TABLE 1: CONTRACTED PROVIDERS COMPLAINT SUBMISSION TIME FRAMES

Level 1 Provider Complaint

Type of Complaint	Days to File	Reviewing Entity
Level 1 — Pre-service Utilization Management (UM) appeal on behalf of member	60 calendar days from the date of the Notice of Denial	OneCare Grievance and Appeals department All pre-service appeals are processed under the member appeal process by CalOptima Health.
Level 1 – Post-service UM appeal	60 calendar days from the date of the Notice of Denial	Entity that issued the Notice of Action.
Level 1 — Provider Claim Dispute Resolution complaint	365 calendar days from date of the remittance advice (RA)	Entity that issued the payment or RA

Level 2 Provider Complaint

Type of Complaint	Days to File	Reviewing Entity
Level 2 — Pre-service UM appeal on behalf of member	60 calendar days from the date of the Notice of Denial	CalOptima Health Grievance and Appeals Resolution Services (GARS) Note: GARS will automatically submit the Level 1 appeal to Medicare Independent Review Entity if the appeal is not resolved wholly in favor of the member
Level 2 — Post-service UM appeal disputing the UM Level 1 decision	60 calendar days from the date of the UM Level 1 decision issued by CalOptima Health or a health network	CalOptima Health GARS
Level 2 — Disputing a health network's Level 1 Provider Claim Resolution decision	180 calendar days from the date of the Level 1 decision issued by a health network	CalOptima Health GARS

All non-contracted providers should adhere to the filing time frames in Table 2.

TABLE 2: NON-CONTRACTED PROVIDERS COMPLAINT SUBMISSION TIME FRAMES

Level 1 Provider Complaints

Type of Complaints	Days to File	Reviewing Entity
Level 1 — Pre-service member appeal	60 calendar days from the date of the Notice of Action	CalOptima Health GARS All pre-service appeals are processed under the member appeal process
Level 1 Provider Dispute Resolution Request — Disputing the underpayment	120 calendar days from date of the receipt of the notice or RA in dispute	Entity that issued the payment or decision, either health network or CalOptima Health
Level 1 Provider Payment Appeals — Appealing a denial of payment, downcoding, bundling, diagnosis related group (DRG), level of care or rate of payment denials	60 days from the date of the receipt of the notice or RA	CalOptima Health GARS Note: CalOptima Health GARS will automatically submit the Level 2 appeal to Medicare Independent Review Entity if the appeal is not

Type of Complaints	Days to File	Reviewing Entity
(must submit signed Waiver of Liability form)		resolved wholly in favor of the non-contracted provider

Level 2 Provider Complaint

Type of Complaint	Days to File	Reviewing Entity
Level 2 — Disputing the health network Level 1 Provider Claim Resolution decision	180 days from the date of the health network Level 1 Provider Dispute Resolution Request decision	CalOptima Health GARS

CalOptima Health Policies and Procedures:

MA.9001: Complaint Process

MA.9005: Payment Appeals

MA.9006: Provider Grievance Process

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

R3: REQUIRED DOCUMENTATION FOR COMPLAINTS

When filing a provider complaint, it is critical that the provider includes complete documentation to support their 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 before an appeal for denial of payment can be processed.

TIPS FOR DOCUMENTATION

1. **Provider Dispute Resolution Request Form – Level 2 —** To submit a complaint regarding a health network's response to a Provider Dispute Resolution (PDR) Level 1 submission, the provider should complete a Provider Complaint Resolution Request Form. To obtain a copy of this form, visit the Providers section of the CalOptima Health website.
2. **If CalOptima Health is at risk for payment, Level 2 dispute rights are not provided —** If you disagree with CalOptima Health's provider dispute decision, you may submit a government claim.
3. **Written documentation** — When submitting a PDR form or a letter, remember to include the following information:
    a. Provider name and Provider Identification Number (PIN)
    b. Contact information
    c. Copy of the original claim and/or the authorization request, when applicable
    d. Patient's name, when applicable
    e. Patient's Medicare Beneficiary Identifier (MBI) or client index number (CIN), when applicable
    f. Date of service, when applicable
    g. The specific services and/or items in dispute, when applicable
    h. The original claim number, when applicable
    i. Copy of remittance advice (RA), Level 1 PDR response or denial notices, when applicable
    j. 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
4. **Incomplete information** — Claims disputes submitted with incomplete information will be returned to the provider clearly identifying the missing information necessary for the review and resolution of the dispute. The provider has 30 working days from the returned dispute/complaint notice date to resubmit with the additional information. If the information is not submitted, or not submitted within the time frame, the dispute/complaint is closed without further action.
5. **Resolution** — All Medi-Cal and contracted Medicare 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. Non-contracted Medicare provider appeals are resolved within 30 calendar days from the date of receipt**,** and a signed Waiver of Liability is required.

CalOptima Health Policies and Procedures:

HH.1101: CalOptima Health Provider Complaint

MA.9001: Complaint Process

MA.9005: Payment Appeals

MA.9006: Provider Grievance Process

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal 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 Health provider complaints. Note that where you file your complaint depends upon whether:

- You are contracted with CalOptima Health or a CalOptima Health-contracted health network
- The complaint is related to a decision made by CalOptima Health or a CalOptima Health-contracted health network
- The complaint is a Level 1 (initial appeal or payment dispute) or Level 2 reconsideration request of the Level 1 Provider Dispute Resolution (PDR) decision

To assist your patients in filing a member complaint, refer them to OneCare 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 Health website.

WHERE TO FILE A COMPLAINT

- **Level 1 Complaints** — Use the table below to identify where to send provider disputes

Level of Dispute	Addresses
Level 1 Provider Appeals and Payment Disputes CalOptima Health-contracted health network claim and non-claim complaints related to decisions rendered by CalOptima Health-contracted health networks	Send to applicable CalOptima Health-contracted health network See **Section B1: CalOptima Health Department and Program Contact Information**
Provider Appeals and Payment Disputes CalOptima Health claim and non-claim disputes related to decisions rendered by CalOptima Health	CalOptima Health Attention: Grievance and Appeals 505 City Parkway West Orange, CA 92868
Level 1 Non-Contracted Provider Appeal Denials of payment for Medicare-covered services (A signed Waiver of Liability is required)	CalOptima Health Attention: Grievance and Appeals 505 City Parkway West Orange, CA 92868
Level 1 and Level 2 Provider UM Appeals Post-service authorization appeals for decisions made by CalOptima Health Utilization Management (UM)	CalOptima Health Attention: Grievance and Appeals 505 City Parkway West Orange, CA 92868

- **Level 2 — Contracted Providers**
  Disputes related to a CalOptima Health-contracted health network Provider Dispute Resolution Request or other non-claim issues (UM Level 2 Appeal) not resolved at the health network level should be sent to:

  CalOptima Health
  Attention: Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868

- **Level 2 — Non-Contracted Providers**
  For a Level 2 Provider Dispute Resolution Request related to claim payment amounts, a provider may file a Level 2 dispute 180 days from the Level 1 Provider Dispute Resolution date or 30 days from the date the health network Level 1 Provider Dispute Resolution Request was submitted, if the provider has not received a response from the health network. Providers should use the following address:

  CalOptima Health
  Attention: Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868
  Fax: 714-246-8562

  Non-Contacted Medicare Provider Appeal: If the denial is upheld or a decision not rendered in 30 calendar days, CalOptima Health Grievance and Appeals Resolution Services (GARS) will forward your appeal case to the Medicare Independent Review Entity, Maximus Federal Services Inc., for a second review if a signed Waiver of Liability is submitted with the provider appeal. If a Waiver of Liability is not included, or the appeal is filed after 60 days and a good cause for filing a late appeal is not provided, GARS will dismiss the appeal.
  - A resolution letter will be sent to the provider by CalOptima Health GARS informing the provider of the outcome at the time of the decision and/or when the case is forwarded to Maximus Federal Services. Maximus Federal Services will send the provider its decision within 60 days of receipt of the case.

CalOptima Health Policies and Procedures:
MA.9006: Provider Complaint Process
HH.1101: CalOptima Health Provider Complaint
MA.9009: Non-Contracted Provider Payment Disputes
GG.1510: Appeal Process for Decisions Regarding Care and Services

This section applies to the following CalOptima Health programs:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

R5: TIME FRAME FOR RESOLUTION OF COMPLAINTS — NON-CONTRACTED PROVIDERS

Complaint resolution time frames for providers who are contracted with a OneCare health network are set as part of the health network's contract with the provider. Check with your OneCare 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 and require a signed Waiver of Liability.

RESOLUTION TIME FRAMES FOR NON-CONTRACTED PROVIDERS

Please use the table below to find the applicable resolution time frames by type of **non-contacted provider complaints:**

Type of Non-Contracted Provider Complaint	Days	Review Entity
Provider Dispute Resolution Request — Payment amount in dispute	45 business days	Entity (health network or CalOptima Health) that issued the payment in dispute
Level 2 Health Network Provider Dispute Resolution Request — Payment amount in dispute	45 business days	CalOptima Health Grievance and Appeals (GARS)
Payment Appeals	30 calendar days	CalOptima Health GARS If no signed waiver is submitted to GARS by the provider, the appeal will be dismissed
Maximus Federal Services Inc., as the Medicare Independent Review Entity for Level 2 Review	60 calendar days	When the decision is not wholly in favor of the provider, GARS will forward the appeal case to Maximus for a Level 2 review. If no signed waiver is submitted to GARS by the provider, the appeal will be dismissed

CalOptima Health Policies and Procedures:

MA.9006: Provider Complaint Process

MA.9009: Non-Contracted Provider Payment Disputes

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

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 or OneCare. All appeals filed by providers on a member's behalf are processed by CalOptima Health'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:
   a. Call OneCare Customer Service at **855-705-8**823 or Medi-Cal Customer Service at **888-587-8088** and request the appeal.
   b. Fax to **714-246-8562**.
   c. Use CalOptima Health's website: www.caloptima.org
   d. Mail the appeal to:
   CalOptima Health
   Attention: Grievance & Appeals
   505 City Parkway West
   Orange, CA 92868

Expedited pre-service appeal:

1. Within 60 calendar days, call OneCare Customer Service at **855-705-8**823 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 Health website.

State Fair Hearing with the California Department of Social Services (CDSS) — For Medi-Cal covered services, providers may submit a request for a state fair 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 Fair Hearing. To obtain copies of these forms, access the Providers section of the CalOptima Health website.

CalOptima Health 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

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

R7: STATE FAIR HEARING RIGHTS

Providers who have completed the CalOptima Health complaint process may request a hearing if the dispute is related to:

- Recoupment of funds based upon audit findings of overpayment
- Imposition of sanctions or penalties
- Suspension or termination of the provider's participation in CalOptima Health, a health network or with a third-party administrator

The hearing request must be submitted to CalOptima Health's Grievance and Appeals department in writing within 15 calendar days from the date of CalOptima Health's, a health network's or a 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 either the decision or any imposed sanctions or penalties.

The hearing will be held within 30 calendar days of 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 as of the date issued by the hearing officer.

HOW TO REQUEST A STATE FAIR HEARING

All hearing requests must be submitted in writing to:

CalOptima Health
Grievance and Appeals
505 City Parkway West
Orange, California 92868

Policies and Procedures:

HH.1101: CalOptima Provider Complaint

MA.9006: Provider Complaint Process

This section applies to the following CalOptima Health programs:

Medi-Cal

R8: LEGAL CLAIMS AND JUDICIAL REVIEW

Because CalOptima Health is a public agency, in addition to compliance with CalOptima Health'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 as applicable.

FOR MORE INFORMATION

Refer to CalOptima Health Policy AA.1217: Legal Claims and Judicial Review for guidance on filing government claims that are separate and in addition to the CalOptima Health administrative grievance and appeals processes.

CalOptima Health Policies and Procedures:

AA.1217: Legal Claims and Judicial Review

This section applies to the following CalOptima Health programs:

PACE

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 Health 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 Health 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

PACE Program	Addresses	Phone Numbers and Website Addresses
CalOptima Health PACE General Information	13300 Garden Grove Blvd. Garden Grove, CA 92843	General: **714-468-1100** Claims: **714-246-8600** Authorizations: **714-468-1100** Website: www.caloptima.org TDD Line: **714-468-1063**

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**.

Medical Care Services	Long-Term Care Services
Physician Services	Transportation
Diagnostic Services	Adult Day Health Care
Hospital Care	Nursing Care
Emergency Services	Social Work
Home Health Services	Physical/ Occupational Therapy
Skilled Nursing Facility Care	Speech Therapy
Hospice Services	Nutrition
Prescriptions	Home Care
Durable Medical Equipment	Audiology, Dentistry, Optometry, Podiatry, Custodial Care

This section applies to the following CalOptima Health programs:

PACE

S2: PARTICIPANT RIGHTS AND RESPONSIBILITIES

ELIGIBILITY AND VERIFICATION

1. The CalOptima Health 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, to be eligible to participate in CalOptima Health PACE, a person must:
    a. Be at least 55 years old
    b. Live in the defined CalOptima Health 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 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 Health PACE is effective the first day of the calendar month following the date CalOptima Health PACE receives a signed signature page of the Enrollment Agreement.

PARTICIPANT BILL OF RIGHTS

CalOptima Health is committed to providing the highest quality of care that promotes the autonomy of the individual participant and instills a level of cooperation between the participant, the family or caregiver, and CalOptima Health PACE providers. To provide an environment that promotes privacy and dignity for each participant, as well as achieve the highest quality of care, CalOptima Health PACE developed a Participant Bill of Rights.

The staff at CalOptima Health 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

The Participant Bill of Rights will be displayed prominently throughout the CalOptima Health PACE center and be included in the Participant Enrollment Agreement Terms and Conditions.

RESPECT AND NONDISCRIMINATION

Participants have the right to considerate and respectful care from CalOptima Health PACE staff at all times and under all circumstances. They have the right not to 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 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, respect, privacy, 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 a participant's 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 IDT verbally or in writing of:

1. Services available from PACE

2. The Participant Enrollment Agreement Terms and Conditions, including rights and any fees fully explained in a manner understood by the participant

3. Rights and responsibilities of participants and 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 provider from 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. To have reasonable and timely access to specialists as indicated by the participant's health condition and consistent with current clinical practice guidelines

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 necessary care in all settings, up to and including placement in a long-term care facility when the PACE organization can no longer provide the services necessary to maintain the participant safely in the community.

3. 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.

4. Request a reassessment by the IDT.

5. Receive an explanation of advance directives and establish them.

6. Receive information about their health and functional status from the IDT.

7. 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 Health PACE participants have the right to communicate with their health care providers in confidence and are entitled to have their health information safeguarded as 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

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 PACE staff

2. Appeal any treatment decision of PACE, its employees or contractors through a process described in the Participant Enrollment Agreement Terms and Conditions

3. To contact 1–800–MEDICARE for information and assistance, including to make a complaint related to the quality of care or the delivery of a service

Refer to Section **S3: Participant Grievance Process** and **Section S4: Participant Appeal Process** for more information about the participant grievance and appeals process.

PARTICIPANT RESPONSIBILITIES

At PACE, we believe that participants and their caregivers 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 participant responsibilities as well.

PACE participants have the responsibility to:

- Cooperate with the IDT in implementing their care plan
- Accept the consequences of refusing treatment recommended by the IDT
- Provide the IDT with a complete and accurate medical history
- Utilize only those services authorized by CalOptima Health PACE
- Take all prescribed medications as directed
- Call the CalOptima Health PACE physician for direction in an urgent situation
- Notify CalOptima Health PACE within 48 hours or as soon as reasonably possible if they require emergency services out of the service area
- Notify CalOptima Health PACE when they wish to initiate the disenrollment process
- Notify CalOptima Health PACE of a move or lengthy stay outside of the service area
- Pay required monthly fees as appropriate
- Treat our staff with respect and consideration
- Not ask staff to perform tasks prohibited by CalOptima Health PACE or agency regulations
- Voice any concerns or dissatisfaction they may have with their care

CalOptima Health PACE will make every reasonable effort to provide a safe and secure environment at the center. However, we strongly advise participants and their families to leave valuables at home. CalOptima Health PACE is not responsible for safeguarding personal belongings.

CalOptima Health Policies and Procedures:

PA.2010: Enrollment and Intake

PA.5040: Participant Rights

This section applies to the following CalOptima Health programs:

PACE

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 the participant's choice free of any restraint, interference, coercion, discrimination or reprisal by the PACE staff

2. Appeal any treatment decision by PACE, its employees or contractors through a process described in the Participant Enrollment Agreement Terms and Conditions

PACE staff share responsibility for participants' care and their satisfaction with the services they receive. PACE has established a grievance process to address participants' concerns or dissatisfactions with the services provided:

1. Participants receive written information on the grievance and appeals process at the time of enrollment.

2. 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. PACE only releases 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. PACE maintains a toll-free number, **1-844-999-PACE (7223)** (TDD/TTY: **714-468-1063**) for filing grievances.

6. Upon enrollment, annually and upon request, PACE will provide written information about the grievance process to participants and/or their representatives including, but not limited to:
    a. Procedures for filling grievances
    b. Telephone numbers for the filing of grievances:
        i. PACE center manager: **714-468-1100**
        ii. PACE Quality Improvement department: **714-468-1100**
    c. Locations where participants may file a written grievance:
        i. CalOptima Health PACE center at which the participant is enrolled
        ii. CalOptima Health PACE Quality Improvement department
        13300 Garden Grove Blvd., Garden Grove, CA 92843

7. PACE staff will not discriminate against a participant because a grievance was filed and will continue furnishing the participant with all services at the frequency provided in the current plan of care during the grievance process.

8. PACE expects providers to be familiar with the established grievance procedures.

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 regulations of the HIPAA.

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.

2. A grievance form will be available from the PACE Quality Improvement department, which may be provided to a participant and/or their representative with the report form if requested. To access the grievance form, contact the PACE center at **714-468-1100**, or refer to the PACE section of the CalOptima Health website at www.caloptima.org/.

3. Any CalOptima Health 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 Health staff member will ensure the participant has written information regarding the grievance process. Staff will document the grievance on the grievance report form on the day it is received or as soon as possible after the occurrence of the events.

2. The PACE Quality Improvement department will ensure documentation of all details of the grievance so that it 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 their representative will receive written notice of the status and estimated completion date of the grievance resolution.

4. The PACE Quality Improvement department will acknowledge the participant's grievance within five calendar days of receipt of the grievance and will be responsible for coordinating the investigation, designating the appropriate PACE staff participants to take corrective actions and reporting the grievance to the 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 Improvement department will 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 if 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 their

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, they are entitled to pursue the grievance with DHCS by contacting:

   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 their representative may request a state hearing from the California Department of Social Services by contacting:

   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
   Fax: 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 their representative must speak at the state hearing or have someone else speak on their behalf, such as a relative, friend or attorney.

4. 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 Improvement program.

HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT GRIEVANCE PROCESS

PACE grievance procedures enable participants and their families to express any concerns, grievances or dissatisfactions they may have so that 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, you 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 their representative call the PACE Quality Improvement department at **714-468-1100**, or provide information on the participant grievance procedure and a grievance form. The grievance form is in the PACE section of the CalOptima Health website at www.caloptima.org**.**

PARTICIPANT COMPLAINTS ABOUT PROVIDERS

- A provider may be notified of a complaint filed against them by a participant or their representative.
- If a grievance related to services provided by a PACE-contracted provider arises, the PACE Quality Improvement department will notify the contracted provider's quality assurance staff.

CalOptima Health Policies and Procedures:

PA.7001: Grievance Process

This section applies to the following CalOptima Health programs:

PACE

S4: PARTICIPANT APPEAL PROCESS

All PACE staff share responsibility for a participant's care and satisfaction. 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. An appeal is a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service including denials, reductions or termination of services. A request to initiate, modify or continue a service must first be processed as a service determination request before the PACE organization can process an appeal.

1. PACE staff is available any time to assist at a participant that wishes to file an appeal. If the participant does not speak English, a bilingual staff member or translation service 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. This includes, but is not limited to, transmission of appeal information between PACE staff member in adherence with 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, and annually thereafter. Appeal process information will also be shared whenever the IDT refuses to pay for a service or when it denies, defers or modifies a request for services. Information includes, but is not limited to:
    a. Procedures for filing an appeal, including a participant's external appeal rights under Medi-Cal and Medicare
    b. Telephone number for filing an appeal:
    PACE center manager: **714-468-1100**
    PACE Quality Improvement 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. A 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 PACE and will be monitored by 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. 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 verbally or in writing any appeal for payment for a service or the denial, deferral or modification of a service.

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. PACE may extend the 180-day limit for good cause.

3. A participant may file an expedited appeal verbally or in writing to PACE if the participant or provider believes 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, PACE shall continue to furnish the disputed service if both of the following conditions are met:
    a. 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, PACE shall not discontinue the disputed service for which an appeal was filed until the appeal process concludes.

6. The PACE Quality Improvement department shall acknowledge a standard appeal in writing within five business days of the initial receipt of the appeal by PACE.

7. For an expedited appeal, the PACE Quality Improvement department shall inform the participant or his or her representative by telephone or in person within one business day of the request for an expedited appeal being received. The PACE Quality Improvement department will explain his or her additional appeal rights, as applicable.

8. PACE shall document all appeals expressed, either verbally or in writing, in an appeal log on the day 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 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 Health website at www.caloptima.org.

10. In the event of insufficient information, the PACE Quality Improvement department shall take all reasonable steps to contact the participant, 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 his or her representatives, shall be given written notice of the appeals process and reasonable opportunity to present evidence or submit

relevant facts for review to PACE, either verbally or in writing.

12. For a standard appeal, the PACE Quality Improvement 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 required by the participant's health condition.

13. For an expedited appeal, 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 Improvement 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 the appeal.
    b. In the event that the 72-hour time frame needs to be extended, the PACE program director shall provide justification to DHCS. The participant shall be notified, both verbally and in writing, by the PACE Quality Improvement department of the pending status and the reason for the delay. PACE shall notify the participant of the anticipated date by which the appeal decision will 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 Improvement department shall provide a written response to the participant or representative within 30 calendar days of receiving a standard appeal, or sooner if required by the participant's health condition. Notice of any favorable decision must explain the conditions of the approval in understandable language.
    b. For an expedited appeal, PACE shall provide the participant's 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.
    c. PACE must furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant on appeal.
2. When the decision of an appeal is not in favor of the participant, that is, the decision to deny, defer or modify a service or payment of a service is upheld, the following shall apply:
    a. Notice of any denial must
        i. State the specific reason(s) for the denial.
        ii. Explain the reason(s) why the service would not improve or maintain the participant's overall health status.
        iii. Inform the participant of his or her right to appeal the decision.
        iv. Describe the external appeal rights under § 460.124.
    b. At the same time the decision is made, PACE must also notify the following:
        i. CMS
        ii. The state administering agency

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 Improvement 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. 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 denial of payment for a service or the denial, deferral or modification of 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 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 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 Improvement 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 Health website at www.caloptima.org.

CalOptima Health Policies and Procedures:

PA.7002: Appeal Process

This section applies to the following CalOptima Health programs:

PACE

S5: PROVIDER RIGHTS AND RESPONSIBILITES

PROVIDER REGISTRATION

CalOptima Health PACE requires providers furnishing services to PACE participants to register with PACE. 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 PACE through the Providers section of the CalOptima Health website at www.caloptima.org. Existing providers can make changes to their registration information online, by phone or by fax.

How to Complete the Initial Registration with CalOptima Health PACE

New providers can register online through the Providers section of CalOptima Health's website. 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 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 the provider may make to his or her registration information include:
    a. Terminations
    b. Additional addresses
    c. Phone/fax/email updates
    d. TIN changes (requires submission of a new W-9)

PROVIDER RESPONSIBILITIES

Participants choose their own provider from among the PACE-contracted PCPs. The provider acts as the primary care manager to all assigned participants and is part of the IDT. Most providers are retained on staff by PACE, although some providers may be contracted by PACE. The vast majority of PACE-contracted providers are medical specialists.

The provider should:

1. See each assigned participant at least every six 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 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 24/7

PACE will assist the providers as follows:

1. Coordinating necessary specialist visits, making appointments with the specialist and transporting the participant to the appointment
2. Discouraging inappropriate use of medications through utilization review and the input of our pharmacy consultant
3. Helping educate the participant on disease prevention practices and early diagnostic services
4. Assisting 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 will acknowledge responsibility for the continuity of care for PACE participants receiving a course of treatment under their 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 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 another 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 another 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 their agreement, including, but not limited to, credentialing, hospital privileges, utilization review, peer review and quality assurance requirements

3. Contracted provider agrees in their 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 longer 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 the 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 **714-246-8600**.

Providers can also contact the PACE director or the Quality Improvement manager at **714-468-1100.** They will work with other CalOptima Health 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 Health'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 GARS at the following address:

CalOptima Health
GARS
505 City Parkway West
Orange, CA 92868

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, GARS will request missing or additional information in writing.

3. The returned complaint will 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, GARS will contact the appropriate PACE or CalOptima Health 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 five 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, providers 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 Health Policies and Procedures:

MA.9006: Provider Complaint Process

This section applies to the following CalOptima Health programs:

PACE

S6: QUALITY MANAGEMENT AND CREDENTIALING

QUALITY MANAGEMENT OVERVIEW

CalOptima Health 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 NCQA. QAPI objectively and systematically monitors and evaluates the quality and appropriateness of participant care on a quarterly and ad hoc basis across the entire continuum of care delivered by CalOptima Health PACE, with the results reported to the Medical Advisory Committee and the CalOptima Health 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 Health 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 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 or as soon as possible

2. Communicate findings of the visit to the PCP, including recommendations for further diagnostic procedures or therapy
3. Coordinate lab and X-ray requests 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 Health website at www.caloptima.org/.

CREDENTIALING OVERVIEW

The purpose of the CalOptima Health 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 Health's Provider Relations department at **714-246-8600**. The information listed below informs the provider of the credentialing process.

In conducting the credentialing and re-credentialing processes for PACE, CalOptima Health 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 Health PACE must be credentialed. Once Credentialing is notified of the provider's desire to participate, the provider will be asked to:

1. Complete the CAQH online application, which is available at https://proview.caqh.org/PR/Registration. This service is used by many hospitals and health plans and is free to the provider.

2. After the provider has completed the CAQH application, the provider must authorize CalOptima Health to access the provider's application. If the provider is a current CAQH user, the authorization must be updated to include CalOptima Health so the health plan may access the provider's application.

3. Additional documents will be emailed to the provider for completion and must be returned for credentialing to begin. These documents include:
   i. Minimum Physician Standards Questionnaire. For more information see **CalOptima Health Policy GG.1643.**
   ii. HIV Specialist Screening Form (if applicable)
   iii. Information Release Form

4. The following documents will be requested from the provider and must be returned for credentialing to begin. These documents may include:
   i. Current W-9
   ii. CV in month and year format
   iii. Explanation for any gap (more than six months) in the education and/or work history or in between
   iv. Malpractice insurance certificate
   v. California State Medical license
   vi. DEA, if applicable

CalOptima Health will render a decision within 180 calendar days from the date the application attestation was signed and all required documents were provided. The practitioner will receive an official letter of the credentialing decision.

HOW TO COMPLETE THE RE-CREDENTIALING PROCESS

- At the time of re-credentialing (every three years after the initial approved credentialing date) and if the practitioner has contracted with CCN, the provider will be contacted to confirm the contact information of both the practitioner and his/her credentialing contact.

- If the provider has not yet completed the CAQH application, the provider will need to do so at re-credentialing. The CAQH online application is available at https://proview.caqh.org/PR/Registration and is free to the provider. Once the provider has completed the CAQH application, the provider must authorize CalOptima Health to access the application. Quarterly, CAQH will notify the provider to update and attest to the contents of the CAQH application.

- CalOptima Health 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**.

CalOptima Health will render a decision within 180 calendar days from the date the application attestation was signed and all required documents are provided. The practitioner will receive an official letter of the recredentialing decision. For questions regarding the credentialing or recredentialing process, call CalOptima Health's Provider Resource Line at **714-246-8600**.

FACILITY SITE REVIEW, MEDICAL RECORDS REVIEW

CalOptima Health conducts a full-scope facility site review of the 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 Health 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 Health 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 facility site access for participants with disabilities to parking, the building, elevators, doctors' offices, 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 Health 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 Health **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 Health identifies deficiencies during the full-scope facility site review, CalOptima Health will give the PACE center a corrective action plan (CAP), which includes specific time frames for addressing identified deficiencies. CalOptima Health 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 Health's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

CalOptima Health Policies and Procedures:

GG.1603 Medical Records Maintenance

GG.1604: Confidentiality of Credentialing Files

GG.1608: Full Scope Site Reviews

GG.1650: Credentialing and Recredentialing

This section applies to the following CalOptima Health programs:

PACE

S7: CLAIMS SUBMISSION AND PROCESS

CalOptima Health 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 Centers for Medicare & Medicaid Services (CMS) website at CMS Forms List.

CLAIMS PROCESSING OVERVIEW

CalOptima Health recognizes that a key component of quality health care is timely and efficient medical claims processing. CalOptima Health 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 Health's claims processing steps.

Claims Filing Time Frames

PACE follows 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 Health Claims department will deny claims not submitted within the appropriate time frame.

Edits/Audits

- CalOptima Health 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 Health will provide a clear and accurate explanation of the specific reasons for adjusted, denied or contested claims.

ELECTRONIC CLAIMS SUBMISSION

CalOptima Health 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 (LTC) (25-1) electronic billing.

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

- 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 HEALTH

EDI Claims

CalOptima Health 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:

Change Health Care
877-271-0054

Office Ally
866-575-4120
www.officeally.com/

CalOptima Health Payer Identification Numbers

Providers should use the following CalOptima Health payer identification (ID) numbers when sending claims electronically to CalOptima Health. (Note that Change and Office Ally have their own payer identification number and each vendor processes different types of claims):

- **Change: Payer ID "99250"** — For submission of LTC claims and Facility claims (UB)
- **Office Ally: Payer ID "CALOP"** — For submission of Professional (CMS 1500) and Facility (UB) claims
- **LTC Services — (25-1 Form Electronic Billing) —** CalOptima Health contracts with Change to provide electronic billing for LTC claims in accordance with the billing requirements and fields on the 25-1 Form. To register for LTC (25-1 Form) electronic billing, please contact Change at the phone number referenced above.

GUIDELINES FOR HARD COPY CLAIMS SUBMISSION TO CALOPTIMA HEALTH

CalOptima Health 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 Health 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.

Following these guidelines helps ensure that CalOptima Health 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 Health, 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-pound 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 HEALTH

1. **Timely filing**
   CalOptima Health has timely filing guidelines that allow the provider one year from the date of service to submit a claim. CalOptima Health 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 on time (e.g., retro eligibility issue).

2. **Paper claims and submission**

When submitting paper claims to CalOptima Health, 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 HEALTH

To submit a claim in hard copy format to CalOptima Health, please mail to:

Original Claims
CalOptima Health 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 Health will provide a clear and accurate written explanation of the specific reasons for such action for adjusted, denied or contested claims.

POTENTIAL BILLING DISCREPANCIES

Should billing discrepancies occur, CalOptima Health will try to resolve the discrepancy. We may request a copy of the medical record or supplemental information. We will supply a clear and accurate written 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 CMS, California Code of Regulations (CCR), Title 22 and policies established by the Department of Health Care Services.

SERVICES PROVIDED WITHOUT PRIOR AUTHORIZATION

In cases where participants pay out of pocket for non-emergency services without prior authorization, CalOptima Health 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 Health Provider Portal located on CalOptima Health's website. New users will need to register with CalOptima Health. Follow the instructions for checking the status of a claim or a check.

For more information regarding CalOptima Health Provider Portal, see **Section E1: Verifying Member Eligibility**.

PROBLEMATIC CLAIMS

Claims for which CalOptima Health 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 Health will pay claims to providers within 45 working days from receipt by CalOptima Health'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 **714-246-8600**, 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 Health's Claims department at **714-246-8600**.

This section applies to the following CalOptima Health programs:

PACE

S8: UTILIZATION MANAGEMENT AND AUTHORIZATION FOR SERVICES

CalOptima Health 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 Health's Utilization Management department because PACE relies on the professional judgment of its staff and PCPs to make medical care decisions. The 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 PACE participants:

1. All non-emergency services must be authorized by PACE prior to services being rendered.

2. Providers who render emergency services must notify PACE within 24 hours or on the next business day after that service has been rendered.

3. 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 Health 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 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 provider has made the decision to refer a participant to an off-site provider, the provider or designee will generate a referral order through our Electronic Medical Record (EMR). The scheduling department will then make arrangements for the appointment and schedule accordingly. The scheduling department will ensure that the specialist has the order prior to the appointment.

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 from 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, STDs, abortion and HIV testing.

DENIAL, DEFERRAL OR MODIFICATION OF A SERVICE REQUEST

PACE will 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. In order to obtain the Notice of Action for Service or Payment Request form, refer to the PACE section of the CalOptima Health website at www.caloptima.org. For questions regarding authorizations, call the PACE center at **714-468-1100**.

PRESCRIPTION DRUG BENEFITS

Each participant enrolled in PACE is entitled to Medicare- and Medi-Cal-covered services, including prescription drugs. The participant's provider is responsible for managing the care of the participant, including prescription drugs. The provider 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 provider 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 Health Policies and Procedures:

AA.1000: Glossary of Terms

MA.1001: Glossary of Terms

This section applies to the following CalOptima Health programs:

PACE

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

Providers must obtain consent for disclosure of a participant's HIV test results (California Health and Safety Code, Section 120980). Providers 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 provider, 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 STD services and AIDS services. Therefore, PACE participants may receive such services from their PACE provider, a non-assigned provider, 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

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 provider in order to ensure continuity of care. Providers 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 regarding 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.

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, ramps
- Water availability/water fountain at wheelchair level
- Elevators with floor selection within reach
- Designated parking spaces
- Accessible bathrooms or alternative access to bathrooms in the building
- Handrails in the bathrooms
- Hallways and exits that are not locked to impair wheelchair access

CalOptima Health will evaluate PACE centers 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 the 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 policies 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.

INFECTIOUS 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 ensure 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 is 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 Health **Policy GG.1618: Member Request for Medical Records**, and CalOptima Health HIPAA privacy policies.

- Federal HIPAA privacy regulations require that participants complete the Authorization for Use or Disclosure of Protected Health Information form to authorize CalOptima Health 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 form, visit the PACE section of the CalOptima Health 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 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 form, visit the PACE section of the CalOptima Health website at www.caloptima.org/.

MEDICAL RECORD CONTENT

Providers must meet the standards for medical record documentation in accordance with NCQA and 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 will 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 must be in a legible handwritten or 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 medications. 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.
- 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 Health Policies and Procedures:

GG.1603: Medical Records Maintenance

This section applies to the following CalOptima Health programs:

PACE

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 Health'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 Health 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 Health PACE staff, PACE staff may access translation services.
- CalOptima Health PACE offers participants access to providers who are culturally and linguistically similar to the diverse population that PACE serves.

Competency

- CalOptima Health 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 Health 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 Health 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 Health 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.

CalOptima Health, A Public Agency

The people in the photographs that appear in this document are models and used for illustrative purposes only.

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